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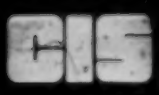

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S. HRG. 100-297

PRESCRIPTION DRUGS AND THE ELDERLY: THE HIGH COST OF GROWING OLD

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 20, 1987

Serial No. 100-9

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PRESCRIPTION DRUGS AND THE ELDERLY: THE HIGH COST OF GROWING OLD

MONDAY, JULY 20, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room 628, Dirksen Senate Office Building, Hon. John Melcher [chairman of the committee] presiding.

Present: Senators Melcher, Heinz, Pryor, Grassley, and Simpson.

Also present: Max I. Richtman, staff director; Christopher Jennings, professional staff; James Michie, chief investigator; Michael Werner, investigator; Holly Bode, professional staff; Stephen McConnell, minority staff director; David Schulke, minority professional staff; Kelli Pronovost, hearing clerk; and Dan Tuite, printer.

OPENING STATEMENT BY SENATOR JOHN MELCHER, CHAIRMAN

CHAIRMAN

The CHAIRMAN. The committee will come to order.

This morning we are going to present this public hearing to describe what the effects of the costs of prescription drugs are on the broad array of retired Americans.

Early this year I asked that the General Accounting Office provide for the committee a study on the catastrophic costs that affect the elderly, and we've been able to obtain from the General Accounting Office that portion of the study that covers prescription drugs.[1] You know, when we think of catastrophic health care coverage we generally think of somebody who is desperately ill and bed-ridden; we think of patients who are incapacitated. But we're finding out that for many Americans—in fact, upwards of 20 million Americans—the highest unmet health care cost for them, is the cost of prescription drugs.

Three-fourths of Americans over 65 years of age require one or more prescription drugs. And three-fourths of the health care costs of older Americans are for prescription drugs.

Between the years of 1980 and 1986, the cost of prescription drugs went up 80 percent. None of this is covered by Medicare, and because most of the private insurance policies that supplement Medicare only cover what Medicare pays, not very many of the private insurance pays for prescription drugs, either.

[1] See appendix, p. 101.

I think we are looking at perhaps one of the most vexing, troubling problems of the elderly of our country; how to pay for the prescription drugs that they must take in order to maintain their health.

Many older Americans on fixed incomes are faced with a rather desperate choice. Because they often don't have enough money to pay for the prescription drugs, they think "maybe I shouldn't get the prescription filled;" or, "perhaps I will not take as much of this prescription as the doctor ordered." They do this in order to stretch out their investment, to help to alleviate the costs that they face at the prescription counter at the drug stores.

They may be forced to choose between getting the prescription drugs or paying the utility bill, or paying for food. Those are very difficult choices, and choices that we on this committee do not believe older Americans should have to make.

We are going to hear from witnesses who are faced with these problems. We want to learn from them in their testimony how these costs affect them and what their suggestions for improvement are. We will also hear from Dr. Helene Levens Lipton, coauthor of the soon to be released book, "Drugs and the Elderly," as well as from representatives of the American Association of Retired Persons, the American Pharmaceutical Association, the American Medical Association, the Pharmaceutical Manufacturers Association, and from the Administration.

That is our hearing today, and with it the Aging Committee will take a step toward coming up with proposals for the Senate that will help to correct what we believe is one of the most aggravating and serious problems that older Americans face.

[The prepared statement of Senator Melcher follows:]

PREPARED STATEMENT OF SENATOR JOHN MELCHER, CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING ON PRESCRIPTION DRUGS AND THE ELDERLY—THE HIGH COST OF GROWING OLD

Good morning. On behalf of my colleagues on the Special Committee on Aging, I'd like to welcome everyone to this morning's hearing on the impact of drug costs on older Americans and the need for expanded prescription drug coverage under the Medicare program.

I called today's hearing to investigate how prescription drug costs affect the everyday lives of our elderly. Older Americans are always telling me about the terrible financial burden prescription drugs place on their fixed incomes. During my travels across the nation, too many of them have told me that they have been forced to choose between taking the medicine that their doctors tell them they need and eating a meal or paying an electric bill. These kinds of situations are totally unacceptable and we cannot rest until we find the best ways to resolve them.

Today, I am releasing a letter report on the prescription drug issue which was prepared for me by the General Accounting Office (GAO). GAO's findings confirm that my conversations with the elderly about this issue were not the exception but the rule.

According to the report, prescription drugs are the largest out-of-pocket health care expense for three out of every four elderly person. Even more startling, GAO cites a Public Health Service report which finds that 15.5% of every older American who requires prescriptions say they are unable to pay for their drugs.

Though the elderly represent only 12% of the population, they consume 30% of all prescription drugs. Further, the costs of the prescription drugs they are taking have risen about 80% in the last six years (two and one half times faster than the rise in consumer prices overall) and 25% of our seniors are taking three of more prescription drugs. At a time when the American Association of Retired Persons reports that over half of this nation's seniors receive no assistance from insurance or

other coverage in paying for their prescription drugs, it's easy to see why our elderly live in fear of needing yet another prescription.

These Americans know better than anyone that they cannot look toward the Medicare program for coverage of out-of-hospital prescription drug costs. While Medicare will pay for the drugs necessary to get our elderly out of the hospital, it won't pay for the prescription drugs they need to stay out of the hospital. In other words, we discharge our responsibility in this area upon the Medicare beneficiary's discharge from the hospital.

After hearing today's testimony, it is my hope and expectation that there will be absolutely no disagreement that there is a need for additional Federally-sponsored prescription drug coverage. I've always believed that effective governing means prioritizing the many needs that confront us. I hope that we will leave today's hearing with the understanding that this issue is one of the highest priorities before us.

In the near future, the Senate will bring to the floor its version of the catastrophic health care legislation. One of the most debated issues surrounding this important bill will be whether or not to include a prescription drug provision. I believe this hearing will provide important information for this debate.

I'm looking forward to the testimony of today's witnesses. I hope they will give us a clearer picture of the prescription drug crisis and what can be done to give millions of Americans a cleaner bill of health.

The CHAIRMAN. Senator Heinz.

STATEMENT BY SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, first I'd like to commend you on holding these hearings. I know we have a very full panel of witnesses today, and I'm anxious to hear from them. I congratulate all of them—I know some of them have come a long way to be here—for helping us build the case that we think is important if we're going to succeed in developing an outpatient prescription drug coverage benefit under Medicare.

As the Chairman may know, I am fortunate to serve on the Senate Committee on Finance and on the Health Subcommittee of Finance, and in conjunction with the development of a so-called "catastrophic coverage" bill, I have proposed in that committee a prescription drugs benefit. That benefit is at this point under review by Senate Finance Committee staff, and it is my hope—indeed, it is my expectation—that we will be able to develop, and I will offer on the floor of the Senate, a workable, affordable, meaningful and successful coverage program for prescription drugs under Medicare.

The work of this hearing today is going to be very important, as I mentioned at the outset, to elaborating the case. It is not simply a question of statistics, although the statistics which suggest that although the elderly are 12 percent of the population yet consume some 30 percent of all prescription drugs, that of the $9 billion that the elderly pay for prescription drugs each year, $7.3 billion—roughly 80 percent, in other words—comes out of their pockets. Those are compelling macroeconomic statistics, but equally compelling are the cases, as evidenced by one of my constituents, who must pay an average of $180 a month out of a rather modest Social Security check, just to get the medications that he needs in order to function.

The diseases that we're talking about these drugs combatting are diseases like arthritis and hypertension. There is a certain irony that, although we have spent billions of dollars in health research developing treatments and cures for patients and the elderly, and we have made a tremendous amount of progress, therefore, in com-

batting many of these diseases, at the same time, many senior citizens are road-blocked from obtaining access to these wonder drugs that have been developed with them in mind.

One study within the last two years showed that cost was a factor in one out of every three senior citizens deciding not to follow their doctors' advice to purchase antihypertensive medication. And indeed, in a recent AARP survey cost overall was given as the second most important reason for failure to fill a prescription.

The most controversial aspect of prescription drug coverage under Medicare is cost. It is considered by the Congressional Budget Office and by the Office of Management and Budget to be potentially a very costly benefit, and there is concern that either we won't be able to pay for it or that the costs will be so great that it will outstrip any estimate that anybody has. I don't think that the news is that gloomy, Mr. Chairman, and I just want to submit into the record some evidence that suggests that there are going to be some important savings to Medicare to help offset some of the costs. I brought here today the cost statements to, on the one hand, Medicare, and on the other hand, a private insurer, of two patients, a Mrs. G. and a Mrs. A.[2] Both patients suffered from terminal cancer; both needed chemotherapy. Mrs. G. received chemotherapy in a local hospital and Medicare, of course, paid for it because she was hospitalized, and the cost was, to Medicare, $1,900. Mrs. A. received a very, very similar regimen; in her case, it was paid for by private insurance, and the cost for that one treatment—and one treatment was given by the hospital in the case of Mrs. G.—was $800 less, or $1,100.

What that suggests is that if we can treat people, as Mrs. A. was, on an outpatient, home-care basis, we can save considerable money. Right now, Medicare is paying a lot of money because the only way you can get this kind of drug coverage is to be hospitalized, and that in itself is quite costly.

So I don't view, Mr. Chairman, the news on cost as all that gloomy, and so far those people who have been critical of the costs of the prescription drug benefit, at least as of a week or two ago, were not taking into account the kinds of savings that are evidenced—to me, at least—in some of these case histories.

So in conclusion, I want to thank you, Mr. Chairman, for this hearing. I look forward to it, and I think it's going to be very productive.

[The prepared statement of Senator Heinz follows:]

PREPARED STATEMENT BY SENATOR JOHN HEINZ, RANKING MEMBER, SENATE SPECIAL COMMITTEE ON AGING ON PRESCRIPTION DRUGS AND THE ELDERLY

Mr. Chairman, good morning. I want to thank you for calling this hearing today to look at the issue of prescription drug coverage for older Americans.

Providing prescription drug coverage for America's elderly is a dilemma not because the need for coverage is an issue—the need for coverage is well documented and highly quantifiable. Older Americans represent about 12 percent of the population, but consume over 30 percent of all prescription drugs. Almost one in every four seniors will have 5 or more prescription drugs in the medicine cabinet or on

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[2] See p. 6.

the bedside table at any given time. Of the $9 billion older Americans spent for prescription drugs in 1985, $7.3 billion came from their own pockets.

It doesn't take an acute "catastrophic" illness to have catastrophic drug costs. Chronic conditions such as arthritis, which afflicts 11.5 million elderly, or hypertension, which plagues 9.4 million, can lead to hundreds of dollars in drug costs annually.

One of my constituents from Pittsburgh is typical of millions of older individuals facing large out-of-pocket expenses for drugs. He wrote that his income from Social Security was "devastated by the costs of prescription drugs." His costs averaged $180 per month for the past year and he knows of "many others whose limited means are similarly being ravaged."

By what twisted process of reasoning, Mr. Chairman, can we commend ourselves for giant strides in combating and controlling disease with drugs, while roadblocking access to these modern miracles with high costs?

Several recent surveys illustrate the impact of cost on drug use. In an AARP survey, cost was given as the second most important reason for failure to fill a prescription. In an earlier study, as many as 1 in 3 elderly patients reported economic barriers to the purchase of antihypertensive drugs, both new and refill. And this study predates the drug price surge of the 1980s.

Unnecessary hospitalizations, even deaths—certainly unwarranted suffering and pain—have been tied to the failure to take prescription drugs. It's a simple equation of need: subtract essential living costs from a limited, fixed income and nothing remains for medications.

Mr. Chairman, I reiterate that the dilemma we face is not establishing the need to cover prescription drugs, but the method. A drug benefit under Medicare, such as I have proposed in the Senate Finance Committee, will be expensive. But preliminary studies suggest there will be savings to Medicare to help offset some of the costs.

A simple, but graphic case in point is the case of Mrs. A and Mrs. G. Both suffered with terminal cancer, and had essentially the same treatment regimen. The difference in their care was that Mrs. G received chemotherapy in a local hospital—because Medicare would pay only in the hospital—while Mrs. A was treated in her home under a private insurance plan. The difference in cost is astonishing: Medicare paid out $1900 for Mrs. G's hospital treatment, while private insurance paid $1100 for Mrs. A's one-day therapy—an $800 savings. I am confident that we can harness these kind of savings to help pull prescription drug coverage through the Medicare program.

When the catastrophic health care bill comes to the Senate floor, Mr. Chairman, I and several other members of the Finance Committee intend to offer an amendment to add that coverage under Medicare. The final details of this amendment are being worked out now.

I want to thank you again, Mr. Chairman, for calling this hearing. You can count on my support to find a legislative solution to the financial—and physical—burden of the unwieldy cost of prescription drugs for older Americans.

[MRS. "A"]

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k Rd.
Arlington, VA 22202

INVOICE DATE	DATE SHIPPED	OUR ORDER NO	YOUR ORDER NO	TERMS	F.O.B	SALESPERSON	SHIPPED VIA
3/18/86	3/19/86						

QUANTITY	DESCRIPTION	U. PRICE	AMOUNT
	RENTALS OXYGEN TANK # F53477	8.00	8.00
1	IV Pole # 39	18.60	18.50
1	IMED PUMP # 10920	13.50	13.50
	PHARMACEUTICALS		
2	0.9% Sodium Chloride 1000ml	7.20	7.20
1	Anaphylactic Kit (includes airway)	n/c	n/c
1	Heparin 100u/ml 30ml (Hickman/Port Patients ONLY)	3.93	3.93
1	Bacteriostatic Normal Saline 30ml (Hickman/Port Patients ONLY)	3.93	3.93
	MEDICAL SUPPLIES		
3	V1792 Administration Sets	6.66	19.98
2	IMED 9216 Administration Sets	21.27	42.54
2	2C0058 Extension Sets	4.47	8.94
3	20g IV Catheters	n/a	n/a
10	20g 1" needles	1.12	1.12
15	Alcohol Preps	.22	.22
1 rl	Cloth Tape	1.68	1.68
1	IV Start Packs	n/a	4.50
1	NON Kor Needle Systems/Swabsticks(Port Patients)	9.09	9.09
1	Foley Catheter/Catherization Tray (as requested)	10.36	10.36
3	Biosafety Kit (3 pr. sterile gloves/chemo box/bag)	.43	1.29
	5cc syringe/needle	SALES TOTAL:	~~$526.78~~ 154.78

THANK YOU

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ROCKVILLE, MD
(301)

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Arlington, VA 22202

INVOICE DATE	DATE SHIPPED	OUR ORDER NO.	YOUR ORDER NO.	TERMS	F.O.B.	SALESPERSON	SHIPPED VIA
3/18/86	3/19/86						

QUANTITY	DESCRIPTION	UNIT PRICE	AMOUNT
	RENTALS		
	PHARMACEUTICALS		
	~~ACCESSORIES~~ PROFESSIONAL SERVICES		
8 HRS.	CISPLATIN INFUSION	$35.00	280.00
		DUE TOTAL	280.00

THANK YOU

CARE, INC.
RD.
ROCKVILLE, MD 2
(301)

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GLAYDS
Arlington, VA

INVOICE DATE	DATE SHIPPED	OUR ORDER NO	YOUR ORDER NO	TERMS	F.O.B.	SALESPERSON	SHIPPED VIA
3/18/86	3/19/86						

QUANTITY	DESCRIPTION	PRICE	AMOUNT
	RENTALS		
	PHARMACEUTICALS		
1	RX#13004 D5½ NS + 20mEq KCl/500mg MgSO4 1000ml (Pre-Hydration)	9.75	9.75
1	RX#13005 Dexamethasone 4mg/ml 5ml vial	7.47	7.47
3	RX#13006 Benedryl 50mg/ml PFS	3.17	9.51
4	RX#13007 Reglan 100 mg/D5W-50 minibag	62.18	248.72
2	RX#13008 Lasix 20mg/2ml vial	2.15	4.30
1	RX#13009 Cisplatin 73 mg/3% NaCl 300ml	315.05	315.05
1	RX#13010 D5½ NS + 20mEq KCl 1000ml (Post-Hydration)	7.83	7.83
1	RX#13012 Cytoxan 730 mg PFS	66.39	66.39
	PHYSICIAN'S ORDERS		
		SubTOTAL:	$669.02

THANK YOU

[MRS. "G"]

FINAL 04/29/87
CLP.

FEI #

WASHINGTON, D.C. 20010

BIRTH-DATE
02/22/16

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
LUISA		F	71	04/19/87	04/20/87	1

LUISA

SILVER SPRING,MD 20902

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY
1	MEDICARE A	M88	110
1	MEDICARE B	M01	11'

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT $

TAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS

19	VALLEY LAB INFUSI	2790110	26.30	26.30					
19	KIT ADMISSION	3311301	7.50	7.50					
19	IV PUMP SET STERI	3312523	20.80	20.80					
19	CARE LEVEL	1579580	133.50	133.50					
19	FUROSEMI 10MG INJ	2600034	1.80	1.80					
19	DIPHENHY 50MG INJ	2600052	15.60	15.60					
19	PERCOCET TAB	2600055	.50	.50					
19	PERCOCET TAB	2600055	.50	.50					
19	IV INFUS	2600163	17.70	17.70					
19	IV INFUS	2600163	17.70	17.70					
19	IV INFUS	2600163	17.70	17.70					
19	POTASSIU 2MEQ INJ	2600226	.90	.90					
19	POTASSIU 20ME INJ	2600394	.70	.70					
19	POTASSIU 20ME INJ	2600394	.70	.70					
19	METHYLDO 250M TAB	2604045	3.00	3.00					
9	INTERMITT IV FLUI	2604950	8.90	8.90					
9	INTERMITT IV FLUI	2604950	8.90	8.90					
9	INTERMITT IV FLUI	2604950	35.60	35.60					
9	CYCLOPHO 100M INJ	2606528	13.80	13.80					
9	CYCLOPHO 500M INJ	2606530	54.30	54.30					
9	DEXAMETH 4MG/ INJ	2606532	3.30	3.30					
9	MAGNESIU 500M INJ	2606620	1.20	1.20					
9	CISPLATI 10MG INJ	2607625	886.80	886.80					
9	CISPLATI 50MG INJ	2607724	297.80	297.80					
9	LORAZEPA 2MG/ INJ	2607804	4.50	4.50					
9	METOCLOP 5MG/ INJ	2609334	178.40	178.40					
9	ROOM SE02	1579816	325.00	315.00					10.00
0	KIT ADMISSION	3311301	7.50	7.50					
0	KIT ADMISSION	3311301	7.50	7.50					
1	IV INFUS	2600163	17.70	17.70					
1	POTASSIU 20ME INJ	2600394	.70	.70					
T O T A L S			2116.80	2106.80					

INSURANCE REQUIRES ATTACHED CERTIFICATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IS NECESSARY FOR ANY ENTRIES ON THIS BILL WHEN THIS BILL MUST BE PREPARED FOR A INSURANCE CARRIER. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS DUE ME OR ON MY BEHALF FOR SERVICES RENDERED.

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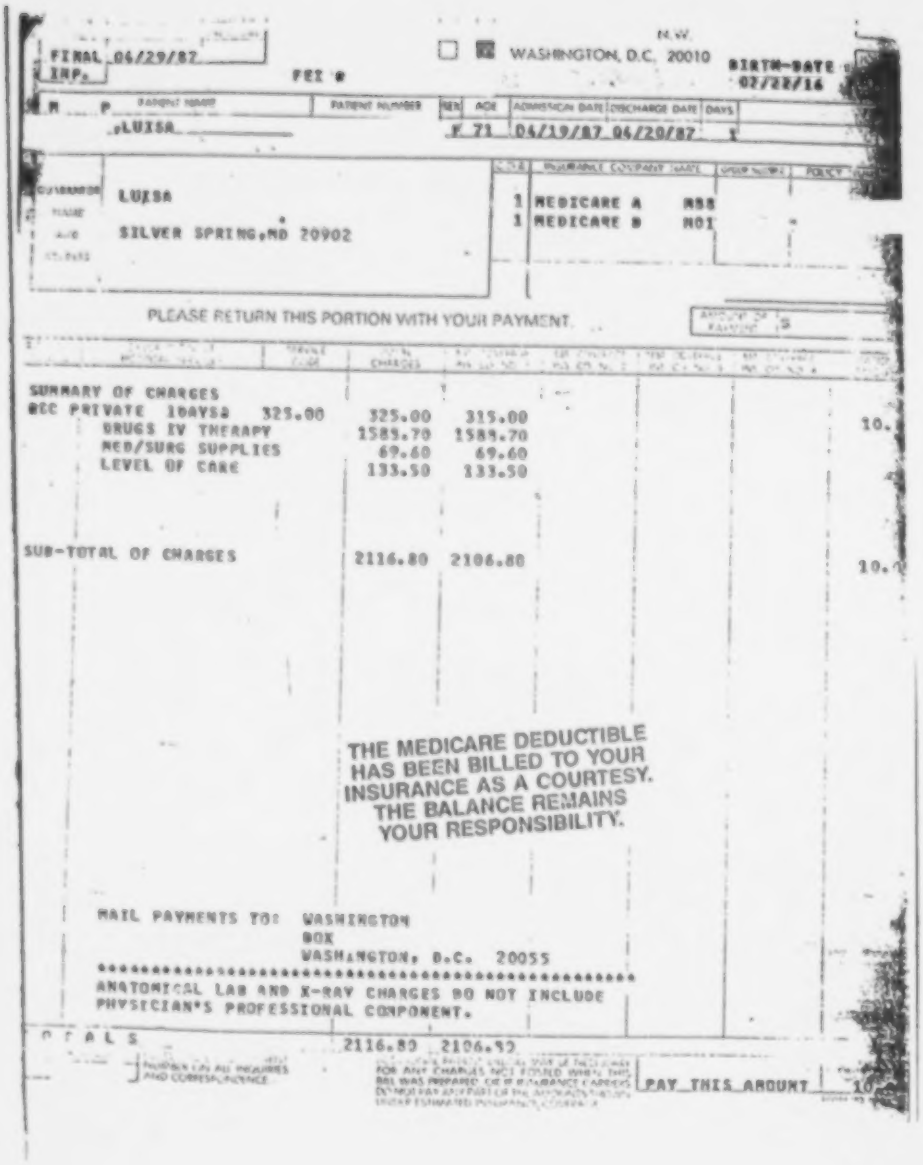
[STAFF NOTE: MEDICARE PAID ABOUT $1900 UNDER DRG 410 FOR THIS PATIENT'S STAY.]



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WASHINGTON, D.C. 20010

FINAL 06/29/87
INP.
FEI #
BIRTH-DATE 02/22/16

P	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
	LUISA		F	71	04/19/87	04/20/87	1

	LUISA	1	MEDICARE A	MSB	
	SILVER SPRING,MD 20902	1	MEDICARE B	M01	

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	SERVICE CODE	CHARGES			
SUMMARY OF CHARGES					
ROC PRIVATE 10DYS@ 325.00		325.00	315.00		10.
DRUGS IV THERAPY		1589.70	1589.70		
MED/SURG SUPPLIES		69.60	69.60		
LEVEL OF CARE		133.50	133.50		
SUB-TOTAL OF CHARGES		2116.80	2106.80		10.

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The CHAIRMAN. Thank you very much, Senator Heinz.

Often, when I'm at a Senior Citizen Center, talking and visiting with the people there, I ask them how many have to take prescription drugs. And generally speaking, almost everybody raises their hand. And on inquiry on what the drugs are for, it ranges from prescriptions for heart conditions to diabetes to arthritis. When I ask how much it costs them out of their own pockets, starting at $30, almost the same number of people who raised their hands the first time, raise them again. Going up the scale, many are locked into costs of around $40 a month or higher. And of course, some are over $100 a month.

We're going to review that situation today, and we're going to ask our three witnesses to tell us exactly how it is for them and what their situations are.

Our first witness this morning is Mrs. Faye Secrist; she's from Front Royal, Virginia. Mrs. Secrist?

STATEMENT OF FAYE SECRIST, FRONT ROYAL, VA

Mrs. SECRIST. Thank you. I am here to represent my mother. She is 83 years old; she will be 84 on December 2nd. I just got her out of the hospital the 8th of July. The doctor wrote prescriptions, 13 of them, that came to $251.87, and she's going to have to continue taking this medication. And that isn't counting the Mylanta that she has to take. Since the 8th, I have bought six bottles. She has a bottle and a half left. That is $4.29 a bottle.

Her medications will run $264 a month. She worked 40 years; she gets $460 a month Social Security. She has other utilities, like her phone, her electric, her oil. Her insurance runs $69 a month; that comes out of her check before she gets anything. And she is a diabetic. She is supposed to be on a strict diet which she does not stay on because it doesn't leave too much for groceries. She thinks if you have a slice of bread and a potato you're not going to go hungry, but that doesn't take care of your blood sugar when you're on a diabetic diet.

Last year she paid out $227 having the furnace worked on, which I think she's getting ripped off, but she won't change the oil company. They come out and put a nozzle in it and charge you $30 for labor, $4 for a nozzle, and she spent, during the winter, $227 for this service. She has a gas bill that runs around $43 every other month. Her electric averages $45 every month. She is on oxygen; when she came home I had to get a new air conditioner put in her bedroom so she could breathe. That was $379, which she owes for that. And we had other problems. I had to get an electrician; the light switch didn't work in her bedroom, and she has to have a light out there but she wouldn't get it fixed because electricians cost too much.

I used to help her when I worked. I would buy her groceries for her; I would buy things for her that she wouldn't buy that I thought she should be eating, but I had to quit work in 1985. My husband had a stroke in 1982 and he's on disability. So financially, I'm not able to help her any more.

She has her fire insurance for her house, $122 a year. And the telephone is about $17 a month; that she has to have. So that doesn't leave but $27, I think, a month for her to buy her groceries.

The CHAIRMAN. Mrs. Secrist, did you say that your mother receives $460 from Social Security?

Mrs. SECRIST. Yes, sir. She worked at a textile mill in Front Royal for 40 years, and they closed it down when she was 65, so that's how long she worked to get that amount on Social Security. She'll be 84 the 2nd of December.

The CHAIRMAN. And she's living alone, in her own home?

Mrs. SECRIST. Yes, she had been living alone, but I'm with her now because—when she went in the hospital she had stomach hemorrhages, and the doctor said that she could have another hemorrhage at any time. So my husband and I have been staying there, taking care of her.

The CHAIRMAN. And out of the $460 she now finds herself with prescription drugs totalling $260 per month?

Mrs. SECRIST. It's $251, what I got for her. These are the drugs that she got when she got out of the hospital.

The CHAIRMAN. Is that going to be the cost every month?

Mrs. SECRIST. That will be—$264 will be the cost every month because she has to have the Mylanta for her stomach.

The CHAIRMAN. Now, she has roughly $200 in income, then, over and above the costs of her prescription drugs to pay all her other bills?

Mrs. SECRIST. Uh huh.

Now, some of these drugs are—this one here is $57.95 a month. A lot of times, that is for her stomach. It's Zantac. And a lot of times, she won't get that filled because it costs so much. She takes Naprosyn for arthritis, and a lot of times she doesn't get that filled because that costs so much. She tries to stagger them so that—she has three that cost $50-some a month. Or maybe one she's taking for her stomach, that she takes four times a day, that's $25 dollars, but it only runs you 17 days, 60 tablets, when you're taking four a day.

The CHAIRMAN. You mentioned a monthly bill that she has to pay—I believe it was $69 for insurance?

Mrs. SECRIST. That's Blue Cross and Blue Shield.

The CHAIRMAN. Do they pay a portion of these prescription drug costs?

Mrs. SECRIST. Yes, they do, they pay a portion. But she gets that—she files at the end of the year, and she gets that, and then she uses that money to pay her taxes—and like having her furnace fixed, to have some in reserve for things like that.

The CHAIRMAN. She gets a rebate, then, at the end of the year for a portion of her prescription drugs?

Mrs. SECRIST. Yes.

The CHAIRMAN. And out of that, she doesn't pay for the prescription drugs; she pays for the——

Mrs. SECRIST. To pay her taxes—like, she was in the hospital; she went in there in November, 1981. She was in there five and a half months. She had knee surgery and they had to take the knee joint out, so when she got her check back this year she got a—she had to have shoes, and she wouldn't get them until the check came back,

then they have to built up an inch and three-quarters. And things like that that she really needs, she'll do without until she gets that back from her Blue Cross/Blue Shield drugs.

The CHAIRMAN. Well, I can understand that. She has to make the choices, then, on how she meets the monthly charges for the prescription drugs?

Mrs. SECRIST. Right.

The CHAIRMAN. And that has an effect on the groceries that she purchases——

Mrs. SECRIST. That's right.

The CHAIRMAN [continuing]. Or any other necessities.

Mrs. SECRIST. I use to—I quit buying her anything for Christmas or her birthday, something that she could wear, and when I was working I would buy her groceries and give them to her. Like Christmas and Mothers' Day and Easter, instead of buying her flowers I would go to the grocery store and buy groceries for her.

The CHAIRMAN. The necessities.

Mrs. SECRIST. But I don't do that now because I'm not working.

The CHAIRMAN. All right. Thank you, Mrs. Secrist.

Senator Heinz.

Senator HEINZ. Mrs. Secrist, you are an example of a very loyal daughter——

Mrs. SECRIST. Thank you.

Senator HEINZ [continuing]. Who has a mother who is getting on in years, 84, and what you are also an example of is a much more common occurrence in this country where we have a retired person—you worked for all your life and retired; your husband is disabled—and you are taking care of another retired person, in this case, your mother. I suppose 30 or 40 years ago that kind of situation would have been relatively rare. We did not have that many people who lived past 80. We had some, but not as many as we would have liked to have had, and today there are literally hundreds of thousands, going on millions, of families, of whom you are a statistical example. And you, therefore, pose for all of us—both as a specific case and as one representing many—a real challenge for our society and for the Medicare program. And as you might have gathered from my opening remarks, I feel that we have to do something about that.

When you described the various costs that your mother is incurring—utility bills, fire insurance, and so forth, and you detailed the cost of her prescription drugs plus her Mylanta—I was keeping track and I came out just about where you did, which is that she has less than $30 a month for food and clothing. What that really means is, she has less than a dollar a day for food and other necessities of infrequent and hard-to-predict demand. And I suppose it would be pretty darned hard for any Member of the Senate to say that they had ever lived on a dollar a day for food. Could you describe for us what that really means to her? You said something about if she eats a potato or a slice of bread, she thinks that's all right.

Mrs. SECRIST. That's true.

Senator HEINZ. Is that about all she can afford?

Mrs. SECRIST. A lot of nights for dinner, she'll fix herself a bowl of oatmeal. She gets her lunches from the Senior Center; they

bring them to her. And for breakfast, she'll probably have a piece of toast and a cup of coffee, and that's how she eats.

Senator HEINZ. So no vegetables——

Mrs. SECRIST. No.

Senator HEINZ [continuing]. No protein, meat, fish. Doesn't sound like she has much of anything that's fresh except maybe that potato. And you said that she is partially diabetic?

Mrs. SECRIST. She is a diabetic.

Senator HEINZ. She is diabetic?

Mrs. SECRIST. Uh huh.

Senator HEINZ. And what does her doctor say about this diet that she's on, as opposed to the one that she's supposed to be on?

Mrs. SECRIST. Well, he doesn't know how she's been eating. When she went in the hospital her sugar was way up, and they had to give her insulin. So far she's only taken the diabetic pills at home. But since I'm there—for instance, for breakfast she's supposed to have a cup of skim milk, one ounce of meat or meat substitute, two starches, and one cup of fruit or fruit juice. That's what she's supposed to be eating. That's what she was supposed to have been eating for the last three or four years.

Senator HEINZ. By failing to have this proper diet, has she either run the risk of going to the hospital prematurely, or has she been hospitalized, because of her inadequate diet?

Mrs. SECRIST. No, she hasn't been hospitalized for that.

Senator HEINZ. Not yet. Do you think there's a risk that she might have to be hospitalized because of that inadequate diet?

Mrs. SECRIST. Oh, yes.

Senator HEINZ. I would just note for the benefit of those who are skeptical about a prescription drug benefit that that is another kind of cost that Medicare incurs through its failure to cover cases like your mother's. If she does get ill from an inadequate diet, she will go to the hospital. She may have to have special therapy; maybe it will be insulin therapy. I'm not a doctor and I don't know. And that will cost many thousands of dollars. It's hard to get in and out of the hospital for anything less than a few thousand dollars these days, no matter how quick——

Mrs. SECRIST. Well, her bill—she just came out—for 15 days it was $18,000-some. She was in there for three weeks.

Senator HEINZ. Well, Mrs. Secrist, I thank you for your testimony. I think you've really provided a very valuable service in helping the committee, and I hope our colleagues in the Senate understand just what the stakes are; not just for you, but for literally hundreds of thousands of people like you, and how failure to attend to the kinds of problems you've described can be very short-sighted, very hurtful to people, and perhaps cost the taxpayer even more money than they think by our failure to have an appropriate kind of prescription drug benefit in place. I thank you very much.

Mrs. SECRIST. Thank you.

The CHAIRMAN. Senator Grassley.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Well, Mr. Chairman, I obviously can't ask any questions of this witness because I didn't hear the testimony, but I

do want to take advantage of your calling upon me to submit a statement that I was going to give. The reason for my absence was because I appeared before Senator Pryor's Subcommittee on Governmental Affairs on whistleblowing legislation that I am sponsoring with Senator Levin, so I ask permission to insert this in the record.

The highlight of my testimony, Mr. Chairman, is only that as we consider legislation that would determine the necessity and our ability to provide for the payment for prescription drugs through some of our existing Medicare and Medicaid programs, that we are cognizant of the fact that these programs tend to grow much more rapidly than we anticipate. And I think we need to take that into consideration. I know you've done that through your request to the General Accounting Office.

I think we also need to be mindful of the fact that as we set out on Medicaid and Medicare, it got way beyond what we anticipated it would cost; and then, through prospective payment systems, we tried to put some sort of brakes on, and in the process it seems like we got every hospital, every health care official as well as every doctor and Medicare beneficiary, mad at us in the process. So I think it falls upon us, the necessity of considering, really, where we're headed here. And I think you need to be commended for opening dialogue on this issue and your emphasis upon that through your request for the General Accounting Office study.

[The prepared statement of Senator Grassley, along with the prepared statements of Senators Pryor, Bradley, Shelby, and Domenici, follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY ON PRESCRIPTION DRUGS AND THE ELDERLY

Thank you, Mr. Chairman.

This hearing is certainly relevant and timely, given that both the Senate and the House of Representatives are considering catastrophic health care cost legislation that includes prescription drug benefits.

I think that none of us can doubt that the high cost of prescription drugs does concern older people. I get a lot of mail on this subject from older constituents who are dismayed and discouraged at what they have to pay for prescription drugs.

I don't think many of us doubt that, for some of the elderly, at least, out-of-pocket expenses for prescription drugs are a significant hardship.

With respect to any legislation to address this problem, however, I think we need to proceed with caution and make sure we address a number of concerns.

We need to decide whether we are trying to develop a program to deal with costs that are truly catastrophic, as opposed to a program that adds a convenient and helpful benefit that is not really necessary to prevent hardship.

If it is a truly catastrophic benefit we are after, we need to identify the population we are trying to help as exactly as we can. Although the price of prescription drugs and increases in those prices may seem reasonable, and may be unreasonable, it does not follow that they necessarily cause a financial hardship for particular older people.

It's not clear to me that we should end up with a program that helps middle and upper income older people who find the high cost of prescription drugs a nuisance, but not really a hardship.

Finally, if we go forward with this program, we need to make sure we don't promise more than we can deliver. If I have learned anything in the years I have spent as a legislator at State and Federal levels, it is that we have a genius for underestimating the future costs of Federal programs. On this point, the General Accounting Office assessment for which Chairman Melcher asked included a brief review of prescription drug programs run by several States. The GAO was emphatic on one point—that the cost of several of those programs had doubled and tripled in relatively short periods of time.

If this is to be the experience of any new Medicare Pharmaceutical Drug Program, we need to ask ourselves whether we will be heading down the same road we have followed with the Medicare prospective payment system. To judge by the mail I receive every week, it sometimes seems that we have managed to make unhappy every hospital, every physician and every Medicare beneficiary, and every new cost-cutting initiative we and the Health Care Financing Administration undertake increases their unhappiness.

I am saying that, if we are going to proceed with a new pharmaceutical Medicare benefit, I hope we do so in a way that doesn't overpromise what we can deliver, and thus lead to more broken promises generating more ill will and disaffection.

Thank you, Mr. Chairman. I have nothing more, and look forward to the testimony of our witnesses.

PREPARED STATEMENT OF SENATOR DAVID PRYOR ON PRESCRIPTION DRUGS AND THE ELDERLY—THE HIGH COST OF GROWING OLD

Mr. Chairman, I'd like to thank you for the scheduling of this hearing today. There has been a great deal of interest expressed this year in a number of issues related to prescription drugs and the elderly, interest which has been fueled by action on the catastrophic health care packages currently pending in the Congress. You could not have picked a more opportune time to begin the aging committee's inquiry into the prescription drug area.

Recently, during Senate Finance Committee consideration of the catastrophic health care package, the many complexities of trying to provide adequate prescription drug coverage for the elderly became increasingly clear to me. I have received an unprecedented number of letters this year regarding the catastrophic health care package, and by far prescription drugs is the single most mentioned and requested benefit. However, many of my constituents have also expressed concerns about the deficit, and have urged that benefits not be expanded to the point where our deficit difficulties are increased. In addition, we hear a great deal about the high cost of drugs, and about the rapid increase in prices.

The basic catastrophic package which the Finance Committee has reported has been designed to pay for itself through an increase in the part B premium. Although we would all, for the most part, like to provide as much as possible in the way of prescription drug coverage for older Americans, the prospect of expanding coverage to include outpatient prescription drugs raises a number of very serious issues:

What level of annual prescription drug costs for an elderly individual is actually catastrophic in nature?

How accurate are the cost estimates we've been provided?

Is the public aware of the increased coverage costs to beneficiaries such a benefit will require?

How accurately can we estimate costs of this benefit in future years, particularly in light of the rapid inflation rates in the prescription drug area?

How do we keep administrative costs of such a complex program within a manageable range?

If we can finally develop an affordable and manageable benefit, how many individuals will it really help? How many senior citizens will end up with increased out of pocket health care costs as a result?

These questions deal primarily with expanded coverage, but lead to the need to examine other, related prescription drug issues, including overutilization and underutilization, substitution of generic equivalencies, and the like.

Another related area of major interest to me is the rise in the cost of prescription drugs. For a number of years now the rise in the cost of prescription drugs has far outpaced the general rate of inflation, and has even outpaced the rate of inflation for general health care costs (the most rapidly rising of all costs). In fact, some studies have shown that over the last two years the rise in the cost of prescription drugs has been four times the general inflation rate. Although the pharmaceutical manufacturers claim their increased charges are due to increased research and development, some studies show that only one-third of these increased corporate revenues have gone for additional R&D. These inflation issues must be examined as part of the entire prescription drug debate.

Mr. Chairman, I realize we will not be able to fully delve into all of these areas today, but I believe this panel will be making a very useful start with our hearing today. I regret I will be unable to stay for the entire hearing as I have another governmental affairs subcommittee hearing I must chair. However, I expect to fully ex-

amine the testimony of all of out witnesses, and would like to extend my thanks to them for their willingness to testify.

Prepared Statement of Senator Bill Bradley on Prescription Drugs

The cost of prescription drugs to the elderly is undeniably a problem of paramount concern. If America's senior citizens are going to receive the quality health care services that they deserve, they must be able to afford essential drug therapy. I commend you, Mr. Chairman, for having this very, very important hearing. It is only through hearings such as this that we can carefully define the problem so that an appropriate solution can be devised.

Personal health expenditures for drugs and sundries amounted to $28.5 billion in 1985, almost one percent of GNP, about $150 for each man, woman, and child. The lion's share of these expenditures were incurred by the elderly. Although they represent only 12% of the the U.S. population, the elderly use 30% of all prescribed drugs. Outpatient prescription drugs represent the largest out-of-pocket health care expenditure for 75% of the elderly; 2.7 million of them incur out-of-pocket drug expenditures of $500 or more each year.

At present, Medicare does not cover outpatient prescription drugs, except for immunosuppressives which are required for organ transplants. Because privates "medigap" policies which cover drugs are expensive and purchased by only a portion of the elderly, 60% of the elderly lack any coverage for home prescription drug therapy. And as the price of drugs continues to outpace general inflation, fewer and fewer elderly will be able to afford private insurance coverage of prescription drugs.

Most older Americans suffer from some form of a chronic condition, and many suffer from multiple conditions. Arthritis affects 53% of the elderly, and hypertension affects 42% of the elderly. That means that a large percentage of elderly receive regular medication for chronic therapy. We know that many elderly need regular medication but simply cannot afford it. As you know, just last year this Committee received testimony from the President of the Arkansas Home Health Association who said that many patients discharged after hospitalization for strokes have reported that they couldn't afford the hypertension pills; some patients were cutting their pills in half themselves to make prescriptions last twice as long! Nurses have reported lack of coverage for home medications as a primary reason for hospitalization and re-hospitalization among the elderly.

Prescription drugs are one of the most cost effective medical care components today. Compliance with prescribed medication cuts down on more acute health care costs. Noncompliance leads to otherwise avoidable physician visits, hospitalization, re-hospitalizations, and increased health care costs, not only for the elderly but for everyone.

Mr. Chairman I'm sure you agree that the Congress is ready to protect the elderly from exposure to catastrophic health care costs. Protection from huge prescription drug costs should be part of the solution, particularly for America's poor and near poor elderly. As a member of this Committee as well as the Senate Finance Committee, I hope to work diligently with my colleagues to see this goal achieved. Once again, I would like to commend you, Mr. Chairman, and the Committee for its efforts to further our knowledge on this most compelling and serious problem.

Prepared Statement by Senator Richard Shelby on Prescription Drugs and the Elderly—The High Cost of Growing Old

Mr. Chairman, I commend you for holding this hearing this morning, and more importantly, I thank you for placing this vital issue of coverage for prescription drugs on the agenda of this committee. I know that I along with the rest of my colleagues on the committee staff have invested in this 100th Congress. Mr. Chairman, you are truly a leader in our quest to find answers to the most pressing problems facing our nation's elderly.

I am unable to be at the hearing this morning due to a previously arranged trip to Alabama. I will be holding town meetings in six counties in my home state today. The open forum format of a town meeting allows many individuals the opportunity to voice their concerns directly to me. Sometimes, if we are lucky, we can begin to resolve their problems immediately. Other times, however, a more long-term effort is called for.

Recently, in my travels through out the state and at a catastrophic coverage field hearing I chaired for the special committee in Birmingham, I have heard more than appeals for help or assistance. I have heard cries for survival from many of the senior citizens I have met. And that, I believe, is what has brought this committee together today—survival. We have gathered to address the high cost of growing

old—particularly with respect to the incredible expenses our elderly face when purchasing necessary prescription drugs.

For years now many of the cognizant policy makers here in Washington have been focusing on the need for expanded Medicare coverage for some of the astronomically high medical costs faced by the elderly. In January, 1987, during his State of the Union Address, we first received word of the President's intention to offer a catastrophic health care proposal. While the Administration's proposal was a welcomed first step, it does not come near my expectations or the expectations of countless senior Americans throughout this country for adequate coverage.

One of the more obvious provisions inherent in a comprehensive plan is more expansive prescription drug coverage. Validity of the need for inclusion of a prescription drug proposal in any major plan considered rests on three simple points. First, all available statistics indicate that persons over age 65 use, on the average, three times the number of prescriptions used by those in the under age 65 population. Secondly, persons over age 65 generally live on fixed incomes. And finally, there is relatively little private prescription drug insurance for this group.

What conclusions can we draw from these principles? Like many of the problems we face, we can clearly identify the need. The solution, however, will be more difficult to reach. Sometimes, we need to look at facts and figures to help us determine to what extent we need to modify our current approach to the problem.

In Alabama, a state of just over 4 million people, the elderly make up 12 percent of the population. In 1985, 228,136 people received Medicaid assistance to purchase their prescription drugs—a good many of these individuals were senior citizens. The approximate number of prescriptions processed by Medicaid in Alabama during that same year was 3,303,229. In 1986, the average price for a prescription in Alabama was $11.46 closely matching the national level of $11.84.

Added to these state figures are statistics which indicate that some 6.7 million older Americans are taking three or more medications daily and one third of the patients in nursing homes receive eight or more drugs in the same time period. Survey results provided by the American Association of Retired People, reveal that 55 percent of the nation's elderly receive no assistance from insurance or other coverage to help pay for their prescriptions. And still, prescription drug prices have been skyrocketing since 1981 and far outpace other items considered in the Consumer Price Index (CPI). Between 1981 and 1985, prescription drug prices rose 56 percent compared with the rise in the overall CPI of just 23 percent.

These facts although startling, lead to an even more unpleasant reality. The increasing cost of prescription drugs has left many of our elderly with no other choice than to alter their medication regimens to stretch their supply. This unconscionable situation will become less the exception and more the rule in the coming years as both the over age 65 population experiences significant growth and the ever increasing cost of medication dictates life threatening choices to this vulnerable group.

Sometimes, however, the figures, statistics, and numbers, mean nothing if we have no understanding of their effect on a personal level. That is why we need to hear from a witness like Mrs. Cleo Lovell from Trussville, Alabama, who can tell us of the financial devastation associated with the high cost of prescription drugs. We are privileged to have Mrs. Lovell share with us her very personal story—the story of a daughter caring for her mother the best way she can and sacrificing years of her own savings to meet her mother's medical needs. I wish to extend a personal thank you to Mrs. Lovell for travelling all this way to appear before the committee. She is an excellent representative of the good people all over this country who provide care to countless senior citizens and I am proud to have her here in Washington.

Mr. Chairman, as work on a catastrophic coverage plan advances in the Congress, I am pleased that this committee has the opportunity to help voice the concerns of many of our nation's elderly on this issue. By being able to show how these problems actually affect many senior citizens and how, under current law, the problems will not cease or subside, but rather will become more pervasive in coming years, our task and the task of our colleagues in both the Senate and the House is clear. This hearing serves to reinforce something we all know, something we have heard over and over again from the senior citizens of our state, and something that we will not allow to be overlooked when legislation is passed. Mr. Chairmen, it is up to the members of this 100th Congress to insure that our elderly are never forced to choose between prescription drugs and survival.

PREPARED STATEMENT OF SENATOR PETE V. DOMENICI ON PRESCRIPTION DRUGS AND THE ELDERLY

Mr. Chairman, I am pleased that you are holding this hearing on the financial impact of drugs costs on the elderly. This is a serious problem for many of our senior citizens. I hope that the testimony we hear today will help us to understand it better.

We are embarking on a new era of Medicare coverage. Protection against catastrophic health costs is a top priority of Congress and the administration. Both the House and the Senate are fast approaching passage of a catastrophic bill. We commend the efforts of President Reagan and Secretary Bowen for bringing this issue to the forefront.

This issue is not new for me. In 1979, I introduced a catastrophic health insurance bill. Perhaps we were a little ahead of our time because now, nearly 8 years later, Congress appears ready to Act.

The Finance Committee bill offers excellent protection against acute care catastrophic health costs. It leaves, however, two major liabilities unprotected: outpatient prescription drug costs and long-term care.

Drug costs are a major liability. Although people over 65 represent only 12 percent of the population, they consume over 30 percent of the prescription drugs. Over 75 percent of the elderly use drugs, yet only 40 percent have adequate health insurance against this high cost item. When added to the cost of medical care, this can truly result in major financial difficulty. Clearly something needs to be done.

We should consider adding a catastrophic drug benefit to the current Finance Committee bill. I stress, however, that the benefit must be truly catastrophic in nature. It must cover the extraordinary costs of prescription drugs.

We need to be cautious as we design this benefit. HCFA estimates that coverage could cost between $5 and $7 billion per year. When this is added to the current catastrophic package, it could put the premiums out of reach for many elderly and possibly jeopardize the entire program.

We must be conscious of future drug use and cost. Prescription drug prices have significantly outpaced inflation in recent years, and any new benefit may encourage unnecessary or overuse. Perhaps the best way to proceed would be to design a benefit with a high deductible and modest coinsurance. This would ensure that the benefit be truly catastrophic and that it not endanger the financial viability of the entire Medicare program.

I look forward to working with you and my other colleagues as we design this protection.

The CHAIRMAN. Thank you, Senator. And thank you, Mrs. Secrist, for your testimony.

Our second witness will be Mrs. Carrie Morris from Troy, Virginia.

STATEMENT OF CARRIE MORRIS, TROY, VA

Mrs. MORRIS. Good morning. I am Carrie Morris. I live at Troy, Virginia; my address is Route 2, Lot 35. I am 72 years old.

I have some bills here. First of all, it's my tax for my mobile home; I live in a mobile home at the trailer park, and that is $14.85. My electric bill is $50.13. I have life insurance, $14.95. I also have a budget fuel bill for $50.00 a month. I have another policy of life insurance for $12.90, and my rent is $70.00, which goes up every year. And then there are some more cancelled checks here.

I go to my meeting, because I am one of Jehovah's Witnesses, and the person charges me $18.00 a month for transportation.

The Health Foundation at Charlottesville, the University of Virginia, charges me $10.00 a month, which I owe them $259.00. And also—the gas company is about $30.00 every three months.

So my income is $487 every month, and it really is up to me, now, between my medicine or my food. I have to decide on whether to buy medicine or buy food, because after all these expenses I have about maybe $30 a month.

The CHAIRMAN. Out of the $487—is that income from Social Security?

Mrs. MORRIS. That's from widow's pension.

The CHAIRMAN. And the bills that you have listed add up to over $400?

Mrs. MORRIS. Yes.

The CHAIRMAN. Now, wait a minute. What about prescription drugs?

Mrs. MORRIS. Well, I have angina and a heart murmur. I take Corgard, which my last prescription was supposed to be $14, and I had to give half, which was $7. In curiosity I opened the bottle and poured the pills into my hand, and it was seven pills. So that means that I will have to wait until I have a pain real bad that I can't stand it before I can take the medicine. And then if that don't work, then I have to take nitroglycerin.

The CHAIRMAN. How often are you supposed to take your Corgard?

Mrs. MORRIS. Every day, one every day. But I haven't been taking it, only waiting until I have a pain to take it.

The CHAIRMAN. How much does one Corgard pill cost you?

Mrs. MORRIS. It must be a dollar because I paid $7 for the half prescription, and I looked in the bottle and there were seven pills.

The CHAIRMAN. Does your doctor know that you're not taking——

Mrs. MORRIS. Yes—he doesn't know that I'm not taking it because I didn't tell him. But I asked him when I was up there about it, and he said, well, just get—I told him, I said, I don't have enough money to get all this medicine. He said, well, just get half of it, then; that will be all right.

The CHAIRMAN. But you're not taking even half of it, are you?

Mrs. MORRIS. No, I'm not taking half. I'm taking only one when I have a pain.

The CHAIRMAN. Mrs. Secrist's mother, who happened to have about the same amount of income per month as you do, had to make the terrible choice of either eating or paying for all the prescription drugs.

Mrs. MORRIS. Well, that's the way it is with me.

The CHAIRMAN. I think it's also a choice, maybe, of whether you live or not.

Mrs. MORRIS. That's the truth.

The CHAIRMAN. I would advise you that you should consult again with your physician. Does he say it's all right for you to take one every other day——

Mrs. MORRIS. No, he told me in the beginning to take one every day; because, you see, the valve to my heart closes and the blood can't go through. So this pill opens it up so that the blood can flow through.

The CHAIRMAN. Well, I understand where you're at; you just simply don't have the money. It's reprehensible that you should be taking the chance on your life by not following your doctor's rec-

ommendation of taking one tablet of Corgard every day in order to be able to buy the food you also need.

Mrs. MORRIS. May I say something else?

The CHAIRMAN. Yes, please do.

Mrs. MORRIS. I still need the Mylanta. I need calcium tablets, but I don't have the money to get them. I have a slight case of osteoporosis. I fall and break my bones. And that, you know, is for my bones. And then the Mylanta is for my stomach because I have esophagal hernia.

The CHAIRMAN. Well, I think we will want to do something to help you, Mrs. Morris, because I believe your choices are too harsh, not compatible with decent, ordinary compassion of Americans. I think you testify to the situation that we must correct.

Mrs. MORRIS. And may I add something else, too? I would rather buy my own food, but I've had to go to Mrs. Kelly to bring me food to last me, because the last week in the month I don't have anything. And this last month, before my check came in, I ate jelly and bread and tea; that's what I had for each meal.

The CHAIRMAN. For the last week?

Mrs. MORRIS. Yes. I called her, and she brought me in enough food to last me until my check came in.

The CHAIRMAN. That's deplorable that you're forced to do that, Mrs. Morris.

Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

Mrs. Morris, as Chairman Melcher said, you have a very similar situation to the previous witness, Mrs. Secrist.

Listening to you recite your costs and the tough choices you are making, I gather you are not only skimping on medicine, you're also skimping on food?

Mrs. MORRIS. Food. That's true, I am.

Senator HEINZ. You're not eating properly and you're not taking the medication you're supposed to take, either.

I realize that the total cost of your medication—at least, that you're supposed to be taking right now, the dollar a day drug, Corgard—would, of course, be about $365 a year. And you would probably have some additional drugs that you should take that you mentioned.

Mrs. MORRIS. Yes, I would.

Senator HEINZ. And it occurred to me that the legislation that most of us have been talking about with respect to coverage for prescription drugs would probably have a deductible of around $500 a year, which would mean that if you spent $360—as you would like to, but can't—you would get no help from that legislation because you would have to have in excess of $500 to get any help, and then only to the extent that your drug costs exceed $500. Now, that would help Mrs. Secrist, whose drug costs are much more substantial than yours; hers are roughly $258 a month. Yours currently are $30 a month.

And secondly, because of the way most people have been talking about financing this prescription drug benefit, even though it didn't benefit you, you would still have to pay—as insurance—your fair share of that cost, which would likely be around $5 or $6 a month, which would be in addition to—it would be deducted from

your Social Security check, which I gather is modest enough already.

And it seems to me that most of the prescription drug bills and coverage that we're talking about, if my understanding and analysis is correct, would not help you; indeed, in a sense it would hurt you, because you would not get—at least, right now—any benefits from this legislation, but you would nonetheless pay for it. Is that correct?

Mrs. MORRIS. I guess so, yes.

Senator HEINZ. Now, there is another idea that some of us have explored, and I have offered an amendment like this in the Finance Committee, and that is for States to be required to have a Medicaid buy-in for people at, say, 125 percent or less of the poverty line. That would, for example, have a State pick up as part of its Medicaid program the costs of prescription drugs for people who met their poverty line test. In the case of 125 percent, that would be about $6,700 a year.

If that was the level at which States made people eligible for Medicaid drug coverage, would that help you? Is your income less than $6,700 a year?

Mrs. MORRIS. Yes, I guess it would. But I was denied the Medicaid. I went to see about it. I had a hearing, and they denied it. For what reason, I don't know; but for one thing, they thought at that time my income was too much, which it wasn't, at about $200-some. So it would help, and I've tried to get it, but I was denied.

Senator HEINZ. What I've described wouldn't make you eligible for Medicaid in its entirety——

Mrs. MORRIS. No, but it helps.

Senator HEINZ. What I have described would be a special eligibility window that would be more generous for prescription drugs for people at, below, or near the poverty line, which the States would at some level be required to cover, and above that level to, say, 150 or 175 percent of poverty, have the option of covering. That $6,700 a year, if that was the income level above which eligibility was denied, would you be below $6,700 a year in income?

Mrs. MORRIS. I probably would be, yes.

Senator HEINZ. You probably would. So that approach might help you?

Mrs. MORRIS. Yes.

Senator HEINZ. Very well.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Mr. Chairman, I have no questions at this time.

The CHAIRMAN. All right.

I thank you very much, Mrs. Morris, for your testimony.

The next witness will be Mrs. Cleo Lovell from Trussville, Alabama.

Please proceed, Mrs. Lovell.

STATEMENT OF CLEO LOVELL, TRUSSVILLE, AL

Mrs. LOVELL. It's not far from Birmingham.

I am honored to be asked to come here and speak on behalf of my mother, who has passed away. I'm still very emotional; it only happened the 5th of May.

My mother had to retire in 1973 because she had emphysema and was a diabetic and had high blood pressure, and three doctors advised her to retire. My mother's dream was always to own her own home; and since my father drank, that never happened, until he got killed in 1959. She got an income—her policy and everything, burial policy and everything—came to $2,500. So after my mother paid for my father's burial, she took the balance of that and paid down on a Jim Walters shell home. In case you don't know what a shell home is, it's all outside and no inside.

She was only making—I don't know exactly how much she was making at the time that she bought the home, but she was only making $2.55 an hour in 1973 working in the linen room at a hospital. They had a credit union, and she borrowed $200 a month from the credit union and would pay it back at $25 every two weeks when she would get her paycheck. We would take that lumber, and her relatives and friends built most of the inside of her home.

Gentlemen, the reason I'm telling you this is because I have tried many times to get help for my mother. I have never had any help except for Medicare and Home Care; thank God for them, because I don't know what I would have done without them.

My mother had a stroke in 1983 that paralyzed her left side, and then later in 1983 she had a stroke in her throat, and she couldn't talk. Between the therapist and myself, we worked with my mother until we could get her to where she could speak. The first thing she wanted to do was to go home. She could walk with a walker, so I called to try to find out what she would have to have in her home that she might be able to go back home. At the time they had something out with the Government that would help pay the people that couldn't afford it to fix things for the crippled people in their homes so they could live at home.

They came out and told me my mother was eligible, told me to get three estimates and send it in to them; told me what my mother would need in order to stay home. She would need furnishings, of course, things for the commode and the bath and a place to go up the steps. I got the three estimates and sent them in. They sent back six months later and said that their funds had run out and that I could try again next year. I could not leave my mother in that shape in her home, so I carried her to my home. Oh, and my mother's home is right behind ours; we gave her a lot to build this on.

On May 20, 1984, my mother had a heart attack and was back in the hospital, so I did not call back the next year. I was afraid for my mother to stay in her house, but I did call Medicaid, welfare, and food stamps to try to get my mother some help. By then, her medical bills were ridiculous, more than she could pay. They told me that my mother could not get help from these three because she owned her own home and was not living in it.

On November 7, 1985, my mother was back in the hospital with a hernia. Gentlemen, I'd like you to remember that each time she came out of this hospital, she came home with at least three more prescriptions, at the very least, and sometimes more.

When they operated on her for the hernia, they found what they called a "jelly substance" in her stomach. The doctor felt that it was cancer. They sent it off; it came back negative, but he told us that he still felt that my mother had cancer.

On May 11, 1986, my mother was back in the hospital with a gall bladder attack. Her doctor told us that he could not operate that soon; my mother's health just wouldn't stand up to it. He gave her another prescription and said, "Now, this is very high, and she'll probably have to stay on it the rest of her life if it works. If she has another attack, please immediately bring her back."

On June 3, 1986, she had another gall bladder attack. We carried her in and they operated the next morning. They sent off another—some more—to see if she had cancer. This thing came back negative. Her doctor told us he was most positive that she had cancer. She had a jelly substance in her stomach, but it would not show up that it was cancer.

We brought my mother home, and I tried again to get some help. Every place I called told me that if I would sell my mother's home, that I could get some Medicaid help for my mother; or if I would put her in a nursing home, they would sell her home and everything in it to help pay for her nursing home. I carried my mother home while I was doing the work in her house, twice a week, got her up the steps, and let her stay in her home.

On August 25, 1986, my mother had a massive brain stroke. I've got to tell you something about this. They didn't think she'd ever talk again, but she did; but what I wanted to tell you, we were sitting up with her one morning and this nice gentleman came to the door, and he said, "Good morning. How's your mother?" I said, "I believe she's much better this morning, thank you." My aunt said, "Who is that distinguished-looking gentleman?" I said, "I don't know; somebody who has someone in the hospital, I guess." So when I got home, I got five bills from doctors I didn't know, which you will get every time you come home from the hospital. So I picked up one and decided I'd just call and see who this Dr. Perrine was. So I asked, and they told me, they said, he's the one that came to see your mother on such-and-such a day in the hospital.

Gentlemen, it was the distinguished-looking guy who stuck his head in the door and wanted to know how my mother was feeling. His bill was $175, and Medicare and Blue Cross paid $150 of it. I paid the other $25. I've got a receipt to show it.

We carried my mother home. I tried again to get some help. They told me the same thing. We found out on May 29 that my mother had a hemorrhage from diabetes behind the retinas in both eyes, that she would have to have laser beam operations. I carried her on May 29, 1986, and got one in her left eye—we couldn't keep her out of the hospital to get them the way we should. On June 30, 1986, I got another one in her left eye. On July 10, 1986, I got one in her right eye. When she went back for an examination about a week after that they told me that they didn't work, she was losing her sight.

I took my mother back to her home for a last look around. She looked at me and she said, "Thank God for being so good to let me work and have a beautiful home like this, and all the things in it. If I never see it again, I'm real proud I still have it." And then

they looked at me and had the nerve to tell me that my mother's not eligible for help because she owns her own home. Her own home that, I might add, had no kitchen cabinets; only a sub-floor, and no inside doors.

Excuse me.

My mother's medicine bill—I told you all this because I want you to know how important it was to me to have my mother, to keep her in the home that she had worked and done so much to have. When we started talking about me coming to Washington, we were talking two years. As I said, my mother had to retire in 1973, but I got it down for two years. Her medicine bill was $3,900.13. Her doctor bill that Medicare and Blue Cross did not pay was $1,560.13. My mother had many things that all shut-ins have to have—this is prescription medicine. She had to have needles, vitamins, cold medicine, medicine for constipation, underpads—12 diapers cost $14.49; you can imagine how often you have to change those—Carrington Gel for bedsores. My mother was in the bed for a year.

I had to carry my mother back to the hospital on October 10th with twisted intestines. They found her cancer. They called in a cancer doctor. We hadn't told my mother. He came in one morning to the door and called me out in the hall and told me who he was, that they had called him in to see about giving my mother chemotherapy.

My mother was real sick. I told him that I would like to wait until the next morning so I could talk to her surgeon, and then all three of us made up our mind that my mother was too sick to take chemotherapy. She stayed 21 days in the hospital, and we carried her back.

The second time she had to go back in the hospital—I got that wrong, sir—the first time that she had the twisted intestine—I'm right, sorry. We carried her home on April 10, 1987. We had to carry her back to the hospital; she had twisted intestines again. The doctors told us that they could not operate again because she would die. They gave her her medication through glucose. She was hemorrhaging at the time when we carried her back in. They gave her her medicine, and she was in the hospital a total of 103 days in the past year. She was furnished her medicine in there, so you add that to the $3,900.13 we paid—if you had added this other 103 days on it, it would have been much more.

We kept my mother—Blue Cross sent us a letter saying that they would help my mother on her medicine. They sent us a card. We went to our drug store, presented the card, got my mother's medicine for a $3 prescription. I thought, Lord, will miracles never cease? This was the most wonderful thing that has ever happened to my mother. Six months later I heard from the drug store that Blue Cross would not pay it—no, it wasn't six months; it was a little over a month—$300-something in debt. Blue Cross wouldn't pay it. My mother had to retire on disability before Blue Cross passed this, so she was not eligible for her medicine, is what Blue Cross told me. I never got any help from Blue Cross on her medicine. I never got any help from anyone.

My mother wasn't like the others. She didn't go hungry. My husband and I worked hard; we had managed to save back a little for our old age, and we were more than glad to spend it to keep our

mother as long as we could. We had put in $9,809.70 in the last two years to help pay my mother's bills. That was the insurance over her house, gas we had to use in the winter to keep things from freezing up, light bills at my mother's house to keep people from breaking in at her house, paying on her medicine. We never told my mother that we were putting money in her bank, because when she lost her sight I had to take over writing all of her checks. My husband is driving a 1968 Falcon, and I'm driving a 1978 Fairmont because we can't afford better cars. That's fine; I'm not complaining about this. What we've spent, we were more than glad to spend. But gentlemen, there are a lot of senior citizens out here in this world today that are like these two people said, that go hungry because they cannot afford to buy medicine and food. I was a Center Manager for three years, and I went in homes; when the heat stroke hit (over 102 degrees)—I don't remember what the year was, but when the heat stroke hit they called us and told us to check in our neighborhood to find out the senior citizens that had no fans. Because of the crime rate, I go in these homes and they have the windows locked down, no fans. I tell them, "Well, we're going to loan you a fan. You're going to die in this heat." "Oh, I can't run a fan. With my doctor bill and my medicine bill, I can't afford to run a fan and run my light bill up because I'm not paying my bills as it is."

I told this one couple, I said, "Please, if you will run this fan for the next few days, I'll try to get you some help on your electric bill." I never got it, but I did get a little help that winter on their gas bill.

I've gone in homes in the winter where older couples would have their bedroom and their kitchen open, with heat; the rest of the house, cold. In their bathroom they'd have a little electric heater that they would turn on only when they took a bath; at other times, they went to the bathroom in a cold room. All this, trying to pay their doctor and medicine bills.

Gentlemen, I think it's time we did something to help them. I'd be glad to answer any questions you have to ask.

The CHAIRMAN. Mrs. Lovell, I agree with you that the life-long desire of your mother to have her own home was one that should have been respected, and I would have done no differently than you did under those circumstances.

I think that what we've heard from you, as well as from Mrs. Secrist and Mrs. Carrie Morris, bears out the results of the General Accounting Office study that I mentioned at the outset of this hearing. For most older Americans, the highest out-of-pocket health care cost that they face is prescription drugs. It works out that way in the case of each of the three witnesses; you with your mother, and Mrs. Secrist with her mother, and Mrs. Morris with herself.

Medicare currently isn't providing the type of protection that older Americans need for prescription drugs. The fact that many older American must make choices between paying for prescriptions and buying other necessities is intolerable.

Senator Heinz mentioned that without adequate nutrition, there is an increased risk of very serious medical problems. For example, controlling the complications associated with diabetes very much

depends on a proper diet. And in Mrs. Morris' case, not taking the drug provided for her heart valve inadequacy could result in death.

So I think perhaps what's coming out of this hearing is that we need a prescription drug benefit under Medicare, and that such a benefit may well have to be income-tested. After all, your mother, Mrs. Lovell, while not commanding high wages during her working years, still contributed to Medicare with the idea that it would be available to her in retirement.

Mrs. LOVELL. May I say, sir, she drew $381, and had to pay this out. And I also forgot to mention that during the course of two years she was taking 36 different drugs.

The CHAIRMAN. Well, it's an impossible situation for her and for you to try to meet all the costs of living and pay for needed prescription drugs. I think that Americans should be reassured that in the future their contributions to Medicare, which are roughly 1.5 percent of their gross wages will be going for the type of protection that they think they're going to need in their older years.

Mrs. LOVELL. I'd also like to mention that I've paid out $796.86—my mother left a balance of $345 after we had put all this money in her checking account. She drew $250 for burial. She had insurance with Vice's Insurance, and they went bankrupt; all of her insurance was paid up and she couldn't afford to take out any more. So I paid out $796.86 since her death, and I've got in bills of $1,236.41 that have come in, and she died May 5th. And if you know anything about hospitals, they just now started coming in for her last trip. So Heaven knows how we're going to pay it, but we will pay it.

The CHAIRMAN. Thank you, Mrs. Lovell.

Senator Heinz.

Senator HEINZ. Mrs. Lovell, you paid out nearly $10,000, as I recall your testimony, of your husband's life savings, to help your mom. Did that put a pretty big dent in your life savings?

Mrs. LOVELL. It almost broke it.

Senator HEINZ. It almost consumed all of it?

Mrs. LOVELL. Almost all of it, yes, sir.

Senator HEINZ. Now, if you hadn't had those savings, what would have happened to your mother? You described how she had to have cataract operations, and you implied that she was going to go blind. In your statement you indicated that her house was really everything that she had. Is it fair to say that she would have had to get rid of the house and go blind, into some kind of a nursing home on Medicaid?

Mrs. LOVELL. There are two things my mother asked me to do; to try to hold onto her home, and not to send her into a nursing home. As you know, she had emphysema real bad. She would have to raise up morning, noon and night, several times; I would raise her up in bed because she'd get to where she couldn't breathe. And she always had a fear that if I put her in a nursing home they would tie her down and she wouldn't be able to get her breath.

Senator HEINZ. And that would have been even if she had been able to see?

Mrs. LOVELL. Yes sir.

Senator HEINZ. So the situation would have been, to her, a frightening situation, made all the more frightening, but she would

never have been able to see where she was if you hadn't been there?

Mrs. LOVELL. Yes.

Senator HEINZ. How are you going to provide for yourself, with all of your life savings having been exhausted, should you at some future time—or your husband at some future time—lapse into the same situation?

Mrs. LOVELL. My husband is retired now. We're living on a fixed income. He has a small retirement pension, plus he gets a Social Security check.

If we get into the situation that my mother was in, I'm hoping my trip today to Washington will take care of a little of that. That's how I'm planning on getting by.

Senator HEINZ. But other than that, no way? Is that right?

Mrs. LOVELL. No way.

Senator HEINZ. Last question. Were you surprised that Medicare didn't help pay for the very high drug costs of your mother?

Mrs. LOVELL. I sure was, sir. I called many times. What would get me more than anything else is because they said that "Because your mother owns a home and does not live in it," when she's practically on death's bed—she thinks she should be living in her home in order for them to help us.

Senator HEINZ. At the outset I said that Mrs. Secrist was an example of a 65-year-old retired person who had another retired person, a parent, and who was a care-giver of that parent, and that was a growing group. You are part of another very large group. About three out of four senior citizens, according to the surveys that have been done—principally by AARP—think that Medicare covers most of the costs of long-term care. That's what most people think, and you know that it does not. You found out the hard way.

Mrs. LOVELL. Yes, sir.

Senator HEINZ. Thank you, Mr. Chairman.

Mrs. LOVELL. Medicare pays a certain part of it, whatever they agree to pay, and Blue Cross pays 20 percent of the balance, and the individual pays the remainder, whatever it is.

Senator HEINZ. Did you think it was that way five years ago?

Mrs. LOVELL. I don't know, really, because I had no experience back then.

Senator HEINZ. Thank you.

The CHAIRMAN. Senator Simpson.

STATEMENT OF SENATOR ALAN K. SIMPSON

Senator SIMPSON. Mr. Chairman, I thank you. I do want to continue to try to participate in this committee's activities and I thank you for going forward with the agenda, and I will be participating, as I say.

I'm sorry, Mrs. Lovell, I missed some of that earlier testimony, but I heard Senator Heinz say that you had expended some $10,000 towards the care of your mother, and I didn't hear—what was the amount of that that went toward prescription drugs?

Mrs. LOVELL. In the last two years—we were picking it up over the last two years so that I would have all the receipts to prove that I had put that much money in there. And her prescription

drugs—now, I can't tell you exactly—her prescription drugs were $3,900.13 for those two years. I can't tell you exactly what part of that money went for that. It did go for medical, because we were buying groceries and we were buying this for mother and buying that for mother. And the upkeep on her house—now, we were keeping her house up, paying the insurance and things that have to be done at her house.

My mother was old, and she was like most senior citizens; she worried, all the time worrying about something. And you try to keep them from worrying as much as you can when they are as sick as my mother was. We would put money as we could into her checking account, and then when mother would say—before she got where she couldn't see at all—"How are we paying for these doctor bills? How are we paying for this medicine?" I said, "Mother, look, you've got so much left in your checking account, so let's don't worry about it." She didn't know that we were putting it in there.

Senator SIMPSON. I know that feeling. My wife's mother is 86 and my mother is 86, and they worry a lot. And we're very fortunate. I don't pretend that's not the case; I am very grateful for that. My wife's mother, that's a different story. She had very little, and we are helping there in every way.

But I'm just trying to get to the actual percentage of cost that would be directed to prescription drugs, because that is the subject of the hearing. These other things are very important, but the Budget Committee has told us—and this is not a partisan issue—that we need to reduce the cost of Medicare by $1.5 billion. It is now $79 billion spent on Medicare, and 10.7 percent of the gross national product is spent on health care in this country.

Now, I have been around here long enough to know that I am not saying that I don't care; I promise you that. I am saying that we need to do something with prescription drugs. I'm not saying we don't need to address that. However, I think there certainly should be a means test. That's what's happening in this Medicare game, there's no way to relate the benefit to the amount of actual need. Until we get to a means test we're not going to get problems with a new drug benefit resolved properly because people give us different figures on what the cost of it is going to be.

What will this cost? What will a new entitlement program cost? What does it mean to the drug companies? You know, I'm not involved with the drug companies, but I understand they put in about 16 percent of their gross income toward research and development. If we're going to create a whole new system, I think we want to be very careful because the cost of it is going to fall back on the Federal Government. And if we end up controlling drug prices, they don't continue with research and development toward the kinds of new drugs that ease the pain and the anguish of senior citizens, I think we want to watch that, too.

I'm just relating my experience here, especially with Part B of Medicare which was originally to be paid 50/50 by the beneficiary and by the Federal Government. Now it's 75 percent by the Federal Government and 25 percent by the beneficiary. We tried to raise that one percentage point a few years ago, and the mail room broke down.

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I'm just saying that when we get to this—and I'm ready to go to some degree of means testing on prescription drugs— but when we get there, the cost will be more than we anticipated. We know that. And when the costs go through the roof we will not allocate that additional cost to the beneficiary; that we know, too. That's the way it is.

So I think we want to be prepared to decide who will bear that cost. The costs, obviously, should be falling on those who can afford to pay, including those within the beneficiary rolls, in my mind. And people like you and your mother and these other people have testified, let's target the assistance. And somehow the word "targeting" doesn't always get said in this committee, and I think it's a very critically important thing that we do, and that is target the resources of the United States on a means test basis to people like yourself in your particular extremity.

With that, I really don't have any——

Mrs. LOVELL. Well, you asked me a question, if I thought how much of that money that I contributed went to my mother's medicine—let's just take what my mother made, up until the first of this year, $381; that she paid $253—that's a month—she paid $253 a year on her house insurance; her light bill, when she did not live in her home, ran about $10 to $14 a month; her fire insurance ran $83 a year; her Blue Cross insurance ran, with the last raise, $52 a month. My mother, eating as a diabetic eating on a diet, give her $10 a week to eat; maybe $20 a month for clothes, because she didn't have to have much, mostly gowns. You take all this out of her $381, there's not much left to pay that $3,900.13. So I imagine most of it went for it.

Senator SIMPSON. No, I hear what you're saying, but the issue today is prescription drugs, not things purchased at a drug store and not medical things. The issue is——

Mrs. LOVELL. They still have to be bought.

Senator SIMPSON. I agree with you, but we are talking about prescription drugs, and I think that's what we have to limit ourselves to. I would like to see what that is, and I hear you completely, and we will proceed, as I know the Chairman will; but I think a targeted approach is something that at least I'm going to be paying close attention to.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mrs. Lovell.

Mrs. LOVELL. Thank you for giving me the privilege, Mr. Chairman.

The CHAIRMAN. I have a rather unusual message that was handed to me a few moments ago. Bill Haddad, Chief Executive Officer of the Danbury Pharmaceutical Company of New York, and also Chairman of the Generic Pharmaceutical Industry Association, wants the witnesses who still need assistance with prescription drugs to know that he will supply each of them with a year's supply of the required drugs. He knows this gesture doesn't deal with the problem, but he was so moved by their testimony that he wants to do this. He will be in touch with the witnesses through the committee staff.

So we have heard from people who have been right there in the trenches, facing the problem of how to pay for prescription drugs,

and now we'll hear from witnesses who perhaps can contribute to a solution.

The first witness is Dr. Helene Levens Lipton, co-author of "Drugs and the Elderly: Clinical, Social and Policy Perspectives."

Dr. Lipton.

STATEMENT OF HELENE LEVENS LIPTON, ASSOCIATE PROFESSOR, DIVISION OF CLINICAL PHARMACY, SCHOOL OF PHARMACY, AND SENIOR RESEARCH ASSOCIATE, INSTITUTE FOR HEALTH POLICY STUDIES, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Ms. LIPTON. Good morning, Mr. Chairman.

The CHAIRMAN. Good morning.

Ms. LIPTON. It is indeed an honor to be called to testify before the Senate Special Committee on Aging on issues related to medications and the elderly.

By way of introduction, I am an Associate Professor in the Division of Clinical Pharmacy, School of Pharmacy, and a Senior Research Associate at the Institute for Health Policy Studies, School of Medicine, University of California at San Francisco. My observations today are based on research and policy analysis that I've done for about a decade, in collaboration with my colleague, Dr. Philip Lee, culminating in a book, "Drugs and the Elderly," that will be published by Stanford University Press this year. Much of my testimony this morning is drawn directly from that work.

The issue before us this morning is to analyze the impact of the high cost of prescription drugs for older Americans and to determine whether there is a need to provide expanded Medicare and Medicaid coverage to meet the elderly's needs for prescription drugs. These are critically important questions.

Drug costs have long posed problems for millions of our Nation's elderly, especially the 80 percent of our country's elders who are afflicted with one or more chronic illnesses, usually requiring long-term maintenance medications. In ny testimony I'll try to describe briefly the issues surrounding drug costs for the elderly and the reasons why the elderly—particularly the elderly poor and near-poor—are especially at risk for drug misuse.

I am going to be providing you with what I hope you will find to be relevant facts and figures. But as a colleague of mine once observed, "Statistics are nothing more than people with the tears washed away." After listening to the testimony of the three witnesses preceding me, I think it's fair to say that in my testimony this morning I'll corroborate in statistical terms what they have so poignantly shared with us in personal and human terms.

To appreciate the impact of drug costs on the lives of our older Americans, I think it is necessary to understand the rapid rate at which drug prices have been increasing over the past few years. In recent years, drug prices have escalated dramatically. They rose faster, relative to inflation, in 1982 than for any year in the entire 1965 to 1981 period. Since 1982, increases in prices for prescription drugs have grown two to three times faster than the Consumer Price Index.

The elderly are adversely affected by these rising drug prices because their burden of chronic disease requires them to take more drugs than people in any other age group. This is borne out by a household survey conducted in 1977 by the National Center for Health Services Research which found that, on average, people use about seven prescriptions per year; but for our Nation's elderly, the corresponding figure was 14 prescriptions. These data have been borne out by other national surveys conducted by HCFA and the FDA. They show, once again, that the elderly are twice as likely to take medications as are their younger counterparts.

The elderly, then, use more drugs—and, by the way, pay more for each prescription—than does any other age group. As a result, they are much more likely to incur, as we have heard this morning, high drug costs.

An important factor related to prescription drug costs is the percentage of those costs borne by elderly consumers themselves. The elderly pay larger out-of-pocket costs for drugs than do people in any other age group. Expenditures for outpatient drugs for the elderly are second only to the cost of their long-term care.

In examining the out-of-pocket drug expenses incurred by the elderly, it is important to determine their economic status. It is only through that examination that we get some sense of what the financial burden they face is actually like.

In 1980, a national HCFA-sponsored survey analyzed prescription drug expenses for the elderly poor, the near-poor, and the non-poor. It found that all three groups had to pay over half their drug expenses out-of-pocket. The near-poor, those above the poverty threshold but below 200 percent of that poverty threshold, had to pay 75 percent of their outpatient drugs out of pocket.

In sum, those who are poor or living slightly above the poverty level are most likely to incur out-of-pocket drug expenditures beyond their means. They suffer from diminished finances and increased incidence of health care problems which create a need for chronic prescription drug use.

Do these high drug expenditures influence the elderly's drug-taking ability? We find, on average, about 50 percent of the elderly do not take their medications safely and effectively. Noncompliance is a complex problem caused by many factors, including drug costs. When we look at the data to try to understand the relationship between drug costs and compliance, the data came from several sources. Information comes from health professionals who have been caring for geriatric patients for many years and who have documented in the literature how the high costs of prescription drugs, particularly those faced by the poor and near-poor, are adversely affecting the health care status of our Nation's elderly.

We also have some literature looking at the relationship between drug costs and compliance. There aren't many studies, but the few that exist suggest that drug costs for our Nation's elders constitute a major economic barrier to their safe and effective use. For example, in one study of about 300 chronically-ill patients who were discharged from a general hospital, researchers found that the financial burden imposed by drug costs was the primary reason offered by elderly patients for their inability to comply with drug treatment. Results indicated that the average monthly cost of drugs pre-

scribed for patients who did not comply with their physicians' drug instructions were three times greater than the cost of drugs of patients who did comply. These studies examining the relationship between drug cost and compliance are few in number. They are limited by small samples of elderly patients and by less than precise definitions of compliance. But this research is important because it shows that drug costs do play a role in the drug therapy decisions made by elderly patients.

I should like to add that there are many studies showing that the number of medications taken by the elderly also affects their drug therapy decisions. The more drugs taken, the greater the probability of noncompliance. Why is that? Patients on multiple medications are more likely that are other patients to suffer from side effects and adverse drug reactions. They are also more confused and less likely to understand how to take multiple medications appropriately. But it is also fair to say that people on multiple medications—and a significant minority of our elderly patients fall under that category—do not comply because their total drug expenditures are so excessive.

To summarize, there is not a great deal of evidence establishing a direct link between high drug costs and elderly patients' noncompliance with drug regimen. But the problem is not that research has failed to demonstrate such a link; rather, the problem is that researchers have paid insufficient attention to what is really a critical problem.

Coming from academe, I am usually one who finds a need to call for an additional study when a great deal of "hard" data are unavailable. (I guess it's kind of an occupational hazard.) But this is one instance in which I really believe that we do not need additional research. If we take the views that have been widely chronicled by health professionals caring for the elderly, that is, that their patients' drug care costs adversely affect health care outcome; if we link that evidence with surveys of patients showing that high drug costs are associated with subsequent noncompliance; if we link that data with personal patient accounts and testimonials which we've been hearing ever since the issuance of the Task Force Report on Prescription Drugs in 1969; and if we add that to what we know about the economic status of the elderly and their burden of out-of-pocket drug costs, I think it is fair to conclude that the elderly are unduly burdened and adversely affected by prescription drug costs. And the poor elderly, and particularly the near-poor elderly, are deserving of financial protection in this regard.

I should like to close by noting that less than safe and effective drug use and inappropriate drug prescribing—which, by the way, is another factor contributing to high drug expenditures for the elderly—can have disastrous clinical and economic consequences: Poor outcomes from drug treatment, increased incidence of adverse drug reactions, and increased use of health care services, especially hospital admissions. Epidemiologic information informs us that conservatively, at least 10 percent of geriatric inpatient admissions are drug-induced and potentially preventable. Some have estimated that these drug-induced illnesses resulting in hospitalization and their subsequent treatment run as much as $4.5 billion per year.

These are the financial costs, but the human costs in terms of impaired quality of life, the inability to afford even the bare necessities of life, and needless deaths, can never be fully chronicled.

Thank you for your attention. I'd be happy to answer any questions you might have.

[The prepared statement of Ms. Lipton follows:]

Statement by

Helene L. Lipton, Ph.D.*

Before the

Special Committee on Aging

United States Senate

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TESTIMONY

I. Introduction

Mr. Chairman, it is an honor to testify before the Special Committee on Aging of the United States Senate on issues related to medication misuse and the elderly.

I am an Associate Professor in the Division of Clinical Pharmacy, School of Pharmacy, and a Senior Research Associate, School of Medicine, at the University of California, San Francisco. The views that I express today are my own and do not necessarily represent the views of those who have funded my research or of my employeer. My observations are based on a decade of study in collaboration with my colleague, Dr. Philip Lee. Dr. Lee and I have examined a wide range of research and policy issues related to geriatric drug use. The results of our analyses--Drugs and the Elderly--will be published by Stanford University Press this year. Much of my testimony this morning is drawn from that work.

The purpose of this hearing is to analyze the impact of high drug costs on the lives of older Americans and to determine whether there is a need for expanded Medicare and Medicaid coverage of prescription drugs. These are critically important questions. The cost of prescription drugs has long posed problems for millions of the elderly, especially for the 80 percent who have one or more chronic illnesses. In my testimony this morning, I would like to analyze the issue of drug costs for the elderly and the reasons why the elderly--particularly the elderly poor and near poor--are especially at risk for drug misuse.

II. Escalating Drug Prices

In order to appreciate the impact of drug costs on the lives of older Americans, it is necessary to understand the rapid rate at which drug prices have been increasing over the years. Prices for drugs rose at rates substantially below the overall inflation rate from 1965 to 1974. Between 1974 and 1982, however, prices increased at about the same rate as overall inflation, 7.5 percent.

In recent years drug prices have escalated dramatically. Drug prices rose faster, relative to inflation, in the federal fiscal year ending September 30, 1982 than for any year during the entire 1965 to 1981 period. Prescription drug prices rose 11.9 percent during the year ending 1982, while overall inflation rose 7.4 percent (Freeland and Schendler, 1983). The same trends continued in fiscal year 1983, when prescription drug prices rose 11.5 percent, and overall inflation, 3.5 percent; in 1984, when prescription drug prices rose 9.6 percent, and overall inflation, 4.3 percent; and in 1985, when prescription drug prices rose 9.5 percent, and overall inflation, 3.6 percent. Thus, in recent years increases in prices for prescription drugs have grown two to three times faster than the Consumer Price Index (CPI) (The Economist, 1985; U.S. Subcommittee on Health and the Environment, 1985).

III. Per Capita Prescription Drug Use and Costs for the Elderly

The elderly are adversely affected by rising drug prices because their burden of chronic illness requires them to take more drugs than do people in any other age group. A household survey, conducted in 1977 by the National Center for Health Services Research (NCHSR), found that the number of prescriptions received by each person using drugs varied markedly with age. Children under 6 years of age received an average of four prescriptions each year, whereas people 65 years of age and over received an average of fourteen prescriptions (Kasper, 1982).

The relationship between the number of prescriptions received and age was further established in a study conducted in 1980 by the National Medical Care Utilization and Expenditure Survey (NMCUES). This household survey of noninstitutionalized Medicare beneficiaries found that the number of prescription drugs received increased with age, even within the elderly population itself. Medicare beneficiaries 65 to 69 years of age received an average of ten prescriptions per year, whereas those 70 to 74 years received twelve prescriptions, and those 75 to 79 received fifteen prescriptions (LaVange and Silverman, 1985). More recent estimates also confirm greater use of drugs by older Americans (Baum, Kennedy and Forbes, 1985).

Not only does the average number of drugs prescribed increase with age

but so does the average price per prescription (Fisher, 1980; Kasper, 1982; Trapnell, 1979). This price difference is probably the result of two factors:

(1) The elderly are more likely than are younger people to take medications for chronic illness. These medications are usually given in more doses per prescription than are medications for acute conditions.

(2) The elderly are more likely than other people to take cardiovascular, antihypertensive, and nonsteroidal antiinflammatory medications--medications that are among the most expensive drug products available.

The average price per prescription for the elderly has increased steadily from $4.00 in 1967 to $8.05 in 1980. This represents a 101 percent increase in price between 1967 and 1980 (LaVange and Silverman, 1985). We estimate that it was about $14 in 1985, based on observed trends in price increases per prescription for the entire population.

The elderly, then, use more drugs and pay higher prices per prescription than do people in other age groups. Thus the aged are much more likely than are others to incur large drug costs (Kasper, 1982; LaVange and Silverman, 1985).

An important factor related to prescripion drug costs is the proportion of costs borne directly by patients. The elderly pay larger out-of-pocket costs for drugs than do people in any other age group (Kasper, 1982). Expenditures for prescription drugs are a major out-of-pocket cost for the elderly, second only to the cost of long-term care. Recent estimates indicate that in 1986 the average annual drug expense for all elderly persons was $155; for those elderly using at least one prescription drug, the average annual cost was $210. Five percent of the elderly incurred total drug expenditures of $600 or more, and approximately 80 percent of these expenditures were paid out-of-pocket. This 5 percent of the elderly accounted for a quarter of total outpatient drug expenditures incurred by the elderly population (Hay, 1987, personal communication).

National surveys conducted by the American Association of Retired Persons (AARP) in 1985 and 1986 provide additional information about the elderly's out-of-pocket drug cost burden. Survey results revealed that over half of those aged 65 and older who were taking prescription drugs on a regular basis received no assistance in paying for drugs from insurance or other health coverage. In 1985, 24 percent of this uninsured group incurred out-of-pocket drug expenses in excess of $480; in 1986, 34 percent incurred expenses in excess of $480. This represents a precipitous increase from the preceding year (Testimony of the American Association of Retired Persons, Subcommittee on Health and the Environment, U.S. House of Representatives, April 21, 1987).

In examining out-of-pocket drug expenditures for the elderly, it is important to determine the economic status of people in this age group to understand fully the extent of the financial burden. In 1980, the NMCUES survey analyzed prescription drug expenses for the elderly poor (people living in families whose income was less than or equal to the poverty level), the near poor (people in families whose income was above the poverty level but less than or equal to twice the poverty level), and the nonpoor (people living in families whose income was greater than twice the poverty level).

All three groups, including those living below the poverty level, had to pay over half of their drug expenses out-of-pocket. The near poor were particularly vulnerable to the burden of out-of-pocket drug costs: almost 75 percent of their drug expenses were paid for out-of-pocket. However, the elderly poor incurred higher average drug expenses, and higher out-of-pocket drug expenses as a percent of family income than did the near poor and nonpoor. In fact, the financial burden of out-of-pocket drug expenses was six times greater for the poor elderly than for those elderly who were not poor (See Table 1) (LaVange and Silverman, 1985).

Table 1
Percent distribution for payments for prescription drugs used by poor, near-poor, and nonpoor* noninstitutionalized, aged Medicare beneficiaries: United States, 1980

Poverty level	Total	Source of payment					
		Medicare	Medicaid	Private plans	Out-of-pocket	Other	Unknown source or unpaid amount
Total	100.0	3.1	10.8	13.9	68.2	3.6	0.4
Poor	100.0	3.0	28.4	7.7	58.7	(**)	0.5
Near-poor	100.0	2.7	8.3	10.7	74.1	3.9	0.2
Nonpoor	100.0	3.6	3.8	20.6	67.4	4.1	0.5

*Categorization of poor, near-poor, and nonpoor beneficiaries is based on annual family income relative to the 1980 U.S. Bureau of the Census definition of poverty level.
**Relative standard error is greater than 50 percent, or sample size is less than 20.

Source: National Medical Care Utilization and Expenditure Survey (LaVange & Silverman 1985).

Thus, those who are poor or are living only slightly above the poverty level are most likely to incur out-of-pocket drug expenditures beyond their means. They suffer both from diminished finances and increased incidence of health problems, which create a need for chronic use of prescription drugs.

Clearly, it is important to take into account income and financial status when analyzing the elderly's total drug charges and out-of-pocket drug expenses. If we examine expenditures only for the elderly as a whole, we obscure the marked disparities in economic status that exist within the 65-and-over age group.

IV. Noncompliance with Drug Regimen: a Prevalent Problem Among the Aged

Do the elderly take their medications appropriately? To what extent do drug costs influence older Americans' drug-taking decisions?

Patient noncompliance with precribed drug therapy (i.e., underuse, overuse, or inappropriate use of drug therapies) is widespread among ambulatory elderly patients, especially those with chronic conditions requiring maintenance medications. The extent of noncompliance among the elderly is generally estimated at about 50 percent (Lipton and Lee, forthcoming), although a recent study has placed the estimate as high as 75 percent (Ostrom et al., 1985). Studies document the nature of the problem: omission of prescribed medication is the major kind of noncompliance among the elderly followed by errors in dosage and timing (Schwartz et al., 1962; Neeley and Patrick, 1968; Lundin et al., 1990). Factors associated with noncompliance by the elderly are presented in Table 2.

Table 2

Factors Associated with Noncompliance among Geriatric Patients

--Multiple drug regimen
--Drug costs
--Duration of drug treatment
--Types of drug prescribed
--Health status
--Social isolation
--Knowledge of the drug regimen
--Patient deference toward health professionals

Given the Committee's interest in the relationship between drug costs and noncompliance, we will concentrate on the economic barriers to safe and effective drug use.

A. Relationship between Drug Costs and Noncompliance

Widespread among health professionals is the view that if elderly patients are unable to afford drugs, their health can be adversely affected. Particular concern has been expressed about the elderly who are on minimal, fixed incomes. Their inability to purchase necessary drugs may cause them to discontinue necessary drug therapy (Smith, 1979; Lamy, 1980; Simonson, 1984). These concerns have been corroborated by elderly patients' personal accounts provided in Congressional hearings (e.g., Testimony submitted by senior citizens before hearings on "Prescription Drug Price Increases," Subcommittee on Health and the Environment, U.S. Congress, July 15, 1985).

The relationship betwen noncompliance and drug costs has not been the subject of much empirical research. The studies that are available, however, indicate that drug costs play a significant role in noncompliance. For example, in a study of 290 chronically ill patients who were discharged from a general hospital, researchers found that the financial burden imposed by drug costs was the primary reason given by patients for noncompliance with drug treatment (Brand, Smith and Brand, 1977). This study was unique in that researchers developed independent estimates of patients' drug expenditures to examine whether there was a relationship between drug expenditures and patients' compliance. Results revealed that the average monthly cost of drugs prescribed for patients who did not comply with their physicians' instructions was almost three times higher than the cost of drugs for patients who complied.

Another study of 82 chronically ill patients discharged from three acute care hospitals found that patients who were noncompliant cited the cost of drugs as reason for their inability to follow physicians' instructions about medications (Donabedian and Rosenfeld, 1964). However, researchers made no independent assessment of actual drug costs.

More recently, a study of 155 elderly residents of an urban subsidized apartment building revealed that 6.4 percent of those surveyed reported drug expense as a problem, even though only 24 percent had insurance covering drug expenditures (Darnell et al., 1986). However, the researchers did not determine whether those who considered drug costs a problem were the individuals most likely to be noncompliant. Nor did they attempt to assess actual drug expenditures and relate these figures to compliance.

These studies are limited by small samples of elderly patients and vague definitions of compliance that make it difficult to assess whether the subjects failed to purchase needed prescriptions because of financial constraints. However, these studies are important because investigators made efforts to take cost factors into account. Drug costs are often neglected in studies designed to elicit information about patients' drug therapy decisions.

B. Relationship Between Multiple Drug Regimen and Noncompliance

There are, however, many studies documenting the relationship between noncompliance and multiple drug regimen--that is, a treatment plan that requires a patient to take a number of drugs. Studies of drug use consistently find that the greater the number of drugs taken by patients, the more likely they are to be noncompliant (Malahay, 1966; Francis, Korsch, and Morns, 1969; Latiolais and Berry, 1969; Weintraub, Au, and Lasagna 1973; Hulka et al., 1975; Parkin et al., 1976; Caplan et al., 1976; Darnell et al., 1986). Because at least 25 percent of the elderly use three or more drugs on a daily basis, the elderly are particularly at risk for noncompliance.

Why does a multiple drug regimen lead to inappropriate drug use? Patients on multiple medications are more likely than are other patients to suffer from side effects and adverse drug reactions, more likely to be confused about how to take their drugs safely and effectively, and, more pertinent to this discussion, more likely to incur large drug expenditures. Thus, we have suggestive evidence, once again, that the elderly's drug costs contribute to inappropriate drug use.

To summarize, there is no definitive research establishing a direct link between high drug costs and elderly patients' noncompliance with drug regimen. The problem is not that research has failed to demonstrate a link, but rather that researchers have paid insufficient attention to this critical problem.

Coming from academe, I am usually the first to call for additional study when hard data are unavailable. However, in this instance, I do not believe that additional research is necessary. If results from the studies examining drug costs and compliance are examined in conjunction with health professionals' concerns, patients' personal reports, and data on the economic status of the elderly and their out-of-pocket drug expenses, a compelling case can be made to support the assertion that the elderly are unduly burdened and adversely affected by the high costs of prescription drugs.

V. Inappropriate Physician Prescribing

Rising prices are not the only factor contributing to the high drug expenditures incurred by the elderly. Inappropriate physician prescribing also causes increased expenditures. Inappropriate prescribing occurs because many physicians do not recognize that the elderly are especially at risk for drug-related problems. Drug-related problems can occur because of the changes in drug distribution, metabolism, excretion, and receptor site sensitivity that accompany aging. Consequently, dosages of such commonly prescribed drugs as digoxin and cimetidine are frequently excessive for elderly patients, resulting in toxicity. More insidious and probably much more common are the subtler drug effects that often escape detection. Chronic excessive prescribing of medications can result in fatigue, confusion, loss of energy,

and a host of symptoms that may either remain completely undetected or be dismissed as "the natural decline of old age."

Education of medical students in geriatrics is, quite simply, inadequate. As a result, most physicians practicing today have never been thoroughly educated about the effects of drugs on the aging body and, conversely, the aging body's response to drugs. It is essential not only for financial reasons but also for the quality of life of our elderly citizens that we develop educational programs about geriatric pharmacotherapy for medical students and for practicing physicians.

VI. Consequences of Inappropriate Geriatric Drug Prescribing and Use

Less than safe and effective geriatric prescribing and use can have enormous clinical and economic consequences: poor outcomes from drug treatment, increased incidence of adverse reactions, and an increased use of health care services, including hospital admissions. Elderly patients' noncompliance with prescribed drug therapy is associated with appreciable mortality: it has been reported, for example, that there are approximately 125,000 deaths each year because of noncompliance with cardiovascular drugs (Levine, 1984). Further, epidemiologic evidence indicates that about 10 to 15 percent of geriatric hospital admissions are drug-related (Graham and Livesley 1983; Frisk, Cooper and Campbell, 1977). The costs of such illnesses are significant: the estimated annual cost of drug-related hospital admissions of the elderly, along with their subsequent treatment, was $4.5 billion in 1983 (Pennsylvania Blue Shield, 1985).

VII. Legislative Goals

Legislation designed to provide financial protection for the elderly who pay high drug costs must take into account the following vulnerable groups:

-- Those elderly on Medicaid who live in states where enormous cutbacks have been made in necessary drug coverage;

-- Those elderly persons living at the poverty level who do not qualify for Medicaid because they live in the 44 states in which the income eligibility for Medicaid is set at a level less than the federally designated poverty threshold--$5,360 for a single person in 1987 (Hill, 1987);

-- Those elderly living slightly above the poverty level--that is, people whose incomes are at or below 125 percent of the federal poverty level (estimated to be approximately 2,250,000 people in 1985) (U.S. Bureau of the Census, 1985).

Moreover, legislation designed to provide financial protection for those in greatest need of drug coverage should simultaneously provide incentives to

promote appropriate drug prescribing by physicians and safe and effective drug use by elderly patients. If we provide only drug benefits to elderly patients--without concomitant incentives to improve geriatric prescribing and use--we may compound already critical drug misuse problems among the elderly and inadvertently add to the nation's mounting health care bill.

I have raised a number of issues for consideration by the Committee and hope that this presentation has been informative as well as provocative. I thank you for your interest, and will be happy to answer any questions.

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The CHAIRMAN. Thank you very much, Dr. Lipton.

Now, your background and experience have built a solid foundation of credibility for your testimony. Is it fair to say that you believe that means testing should be used to cover the costs of prescription drugs for the elderly?

Ms. LIPTON. I would give that careful consideration in addition to other policy options because I believe that the burden of prescription drug costs falls disproportionately on the poor and near-poor groups, who are those living between 125 percent and 200 percent above the poverty line.

I believe that there are certain vulnerable groups, Senator, that might not be helped by the current catastrophic health bills before Congress. I am speaking about those elderly poor covered by Medicaid who are, in fact, not fully eligible because their States have slashed Medicaid coverage quite precipitously. Eleven States do not allow Medicaid recipients to receive more than three drug prescriptions a month. Others limit the number of refills to three per month. I think these are very short-sighted policies, and in the long run we will incur greater expenditures because of the cutback in necessary drug coverage.

I think another very needy group is people living below the poverty threshold who are ineligible for Medicaid because they happen to live in the majority of States that have income eligibility criteria for Medicaid that are below the Federal poverty threshold.

And finally, I think those elderly—and they number about 2.25 million—living slightly above the poverty threshold should also be targeted in any legislation.

The CHAIRMAN. The previous testimony we heard involved women, and their income was $500 or less per month. I don't think any of these witnesses, and millions of other Americans, would want to be called impoverished but those are the people you're talking about, are they not?

Ms. LIPTON. Yes. Further, I think you are quite right in noting that they are all women because about 30 percent of all elderly women have incomes below the poverty threshold. When you examine the total number of elderly poor in our country, almost half of them are women. This is a particularly vulnerable group not only because of their diminished finances but also because of their burden of their chronic illness. Elderly women are prescribed—and take—more medications than do their male counterparts. This is a group particularly in need of attention in public policy.

The CHAIRMAN. Doctor, you have established a summary of the facts as you see them and as you know them to be. Did I understand you correctly that we don't need more studies, we just need to act on the facts as they exist? Is that correct?

Ms. LIPTON. Yes, I certainly think—in terms of the need to provide financial protection of those elderly with high drug expenditures, that is the case.

The CHAIRMAN. Thank you very much, Doctor.

Mr. John Stallworth, Secretary for the American Association of Retired Persons. Mr. Stallworth.

STATEMENT OF JOHN STALLWORTH, SECRETARY, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY JUDITH BROWN, POLICY ANALYST

Mr. STALLWORTH. Thank you, Mr. Chairman. Speaking before you today is a double pleasure because I, this past Saturday, without your permission, used your name before a House Committee on Aging hearing in Boston and pointed to you as one of our champions in view of legislation regarding Supplemental Security Insurance that you sponsored now pending in the Senate. So I guess I owe you; thanks for the use of your name.

The CHAIRMAN. I am flattered, Mr. Stallworth. Please continue.

Mr. STALLWORTH. And thank you again, Mr. Chairman, on behalf of the 25 million members of the American Association of Retired Persons. On my left is Ms. Judith Brown, who is the in-house expert on drug affairs, who will be here to help me answer questions that may come from your committee.

I wish to thank you for this hearing to focus attention on prescription drug costs and coverage. I have sent in a copy of my testimony, complete with statistics on recent price increases and other pertinent data, but I intend to use this time also for some personal comments.

Only 41 percent of Americans over the age of 65 have the protection of insurance coverage for outpatient prescriptions. Prices for prescription drugs began to skyrocket in 1981 and have far outpaced the overall Consumer Price Index ever since. Last year, for instance, prescription drugs rose almost 9 percent, while the general inflation increased by less than 2 percent. High prices affect both the willingness of private insurers to cover drugs, and the behavior of older Americans. An AARP national survey taken in 1986 showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by their doctors. As recently as 1982, the cost of drugs was given as the fourth reason.

Since drugs are one of the most cost-effective medical care components, this change may have the poor result of increasing more costly physician visits, or even hospitalization. Perhaps as much as any type of medical care expense, prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions, the proportion rises to 90 percent. Interestingly, many of those with high drug expenses are not the same persons who would have high expenses from a hospital stay. Rather, older Americans with chronic conditions seem to be the heaviest users of prescription drugs. This is a group that we must be sure to protect. A relatively healthy older person suffering from four common but chronic conditions—arthritis, high blood pressure, angina and an ulcer—would pay over $1,000 in drug costs alone.

I feel triply qualified to speak on this subject. I've been a member of the Massachusetts Board of Pharmacy for 12 years; I'm 75 years old, and I have high blood pressure. I've been taking Inderal for many years, and the price for that drug has recently gone up 118 percent. It has had seven increases in the past four years.

The heaviest users of these drugs are likely to be women living alone. Chronic conditions are problems of the very old, a group that is dominated by widows who are the most financially vulnerable of all the elderly.

Currently, eight States have implemented programs to cover outpatient drugs for elderly residents who meet eligibility requirements. New York, the ninth State, will begin coverage for its plans starting this October. Congressional efforts to implement a drug benefit program under Medicare could be enhanced by studying these successful State programs.

AARP recommends including a prescription drug benefit under Medicare that would provide meaningful coverage to beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include, first, a deductible no higher than $500, with a minimum or no co-insurance payment.

Two, continuation of Medicare's existing prescription drug benefit and Medicaid coverage of individuals up to 100 percent of the Federal poverty level.

Three, we further recommend that beneficiary deductible and co-insurance payments be counted toward the comprehensive catastrophic cap.

Our recommendations for implementation and financing such a benefit are as follows:

Cost containment and systems to encourage generic substitution of equivalent drugs are essential;

A fair pricing mechanism which takes into account average wholesale prices, administrative costs, and other reasonable factors;

Administration of the benefit through participating pharmacies;

The benefit should be phased in over a period of several years; and

The benefit should be financed through a premium and by bringing all State and local employees into Medicare.

The high deductible of this benefit and inclusion of the deductible and co-insurance in the total catastrophic cap are compatible with the principle of catastrophic coverage. The minimum co-insurance would offer a beneficiary significant relief when the cap is reached.

In conclusion, we hope that 1987 will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will have far to go in protecting the Nation against some of its most burdensome health care costs; but in the area of prescription drugs, we can take steps this year to provide a benefit that is fiscally sound and administratively manageable.

I sincerely hope this committee will consider our recommendations and be magnanimous in their help, as you have been gracious in listening to my testimony. Thank you, Mr. Chairman.

[The prepared statement of Mr. Stallworth follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

"PRESCRIPTION DRUGS AND THE ELDERLY -- THE HIGH COST OF GROWING OLD"

before the

SENATE AGING COMMITTEE

Washington, D.C.
July 20, 1987

Presented by:

John E. Stallworth
Secretary, American Association of Retired Persons

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

I am pleased to be here today to represent the American Association of Retired Persons. AARP is a membership organization of 25 million Americans age 50 and older. We are encouraged by your interest in prescription drugs and look forward to working with you to expand protection for older Americans in this vital area.

Before discussing some possible approaches to expanding Medicare to cover prescription drugs, my testimony will discuss some facts that help establish the nature of the problem. Specifically, we will discuss:

1. Drug costs and overall use;
2. Specific areas of need; and
3. Some recent state efforts to help with drug expenses.

Prescription Drugs and Older Americans

AARP has always maintained a keen interest in pharmaceutical issues; older Americans consume a disproportionately high amount of prescription drugs and are less well protected in this area than younger members of the population. In the U.S., persons aged 65 and older represent only 12 percent of the population, but they consume 30 percent of the prescription drugs. And while three-fourths of all adults age 19 to 64 have insurance coverage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection. Although a 1977 survey showed that 41% of the older population have outpatient drugs covered by insurance, it is difficult to ascertain the depth of that coverage or whether that kind of coverage still exists. Since this 1977 figure precedes the dramatic increases in drug prices we have experienced since 1981, we know that many insurance plans have cut back coverage of this troublesome benefit. Further, many of the plans that still exist contain large co-pays, low ceilings and heavy deductibles. The high costs of drugs and the failure of the private sector to offer solutions underscore the need for legislation to protect older Americans.

The reluctance of private supplemental policies to cover drugs surely arises in part from the tremendous growth in the price of pharmaceuticals. Prices for prescription drugs began to skyrocket in 1981 and have far outpaced the overall Consumer Price Index. Between the years 1981 and 1985, prices for

prescription drugs rose 56 percent, compared to 23 percent for general inflation. Last year, prescription drugs rose 8.6 percent, while general inflation increased by only 1.9 percent.

Some individual price increases that have contributed to the overall burden of high drug costs are listed below and their rates and frequencies are alarming:

Product (Manufacturer)	Number of Price Increases	Total % Increase
Inderal 40 mg (Ayerst)	7 increases from 1/83 - 10/86	118%
Lanoxin .125 mg (Burroughs-Wellcome)	5 increases from 9/83 - 3/86	168%
Lopressor 50 mg (Geigy)	6 increases from 3/83 - 7/86	79%
Dyazide (cap) (SKF)	5 increases from 6/83 - 3/86	70%
Tenormin 50 mg (Stuart)	7 increases from 6/82 - 9/86	57%

We have seen no moderation in price increases when the patent for a brand product expires and the product is subject to generic competition. Contrary to accepted market theory, brand name prices continue going up when met with competition. In a rush to offset decreased market share, many companies raise prices significantly in the time period before the brand product goes off patent. In this way, consumers get burned twice: they must pay whatever price demanded while the manufacturer has a monopoly, then they must pay an artificially inflated price for the coming generic product, since generics are usually priced as a percentage of the brand name.

These high prices also affect the behavior of older Americans. An AARP national survey taken in 1986 showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by their doctors. As recently as 1982, this reason was fourth. Clearly, cost has become an increasingly important factor in patients' non-compliance with recommended treatment. Since drugs are among the most cost-effective of medical care components, this increasing noncompliance with prescribed drug regimens may have the untoward result of increasing more costly physician visits or even hospitalizations.

Perhaps as much as any type of medical care expense, prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions, the proportion rises to 90 percent. Interestingly, many of those with high drug expenses are not the same persons who would have expenses from a hospital stay. Rather, older Americans with chronic conditions seem to be the heaviest users of prescription drugs.

Acute and Chronic Conditions and Drug Use

Some who would try to introduce drug benefits gradually would limit the benefit to specific types of drugs. Problems arise here, however. When, for example, do we assume one type of drug is more essential than another? Meaningful distinctions between "life-saving" and other essential drugs are difficult indeed to make. A careful look at drug use suggests that we must be careful to protect the chronic user. Although available data does not offer a clear cut look at the relationship between medical conditions and drug use, we can discern a number of areas where the elderly are likely to be particularly vulnerable to high drug costs. For example, according to AARP's mail order pharmacy, the ten most commonly dispensed drugs are all for the treatment of hypertension and/or heart conditions. More than a third of all elderly persons suffer from hypertensive disease; in fact this is the second most common chronic condition following arthritis. Moreover, costs of such treatment are not cheap. One common anti-hypertensive drug at the AARP pharmacy (where prices are likely to represent an underestimate of costs to most consumers) is $24.45 for 100 tablets--about a one month supply.

Since many older Americans suffer from multiple chronic conditions, the costs of prescription drugs can multiply quickly. For example, a relatively healthy older person suffering from four common but chronic conditions--arthritis, high blood pressure, angina and an ulcer--would pay over $1000 per year in drug costs alone. (See attached Table 1).

As already mentioned, older Americans are very likely to suffer from arthritis or hypertension. In addition, more than a fourth of all the elderly suffer from heart conditions (see Table 2). Diabetes also ranks high among the elderly--affecting over 8 percent of those over age 65. All of these chronic conditions

are likely to require considerable outlays for prescription drugs. The heaviest users of these drugs are likely to be women living alone. Chronic conditions are problems of the very old, a group dominated by widows. And these women are the most financially vulnerable of all the elderly. For example, one-fifth of such women live below the poverty line.

Thus, while we hear a lot about immunosuppressant drugs and other extremely expensive pharmaceuticals, it is likely to be the more common ailments that lead to high drug expenses, and the burden will be greatest on those least able to pay. The most common prescriptions are for cardiovascular problems, pain relief, and central nervous system problems (see Table 3). These are not the glamorous drugs--merely the ones needed by the elderly to help sustain a reasonable life style. Moreover, three of the four chronic conditions in our example above are life-threatening if essential medications are not taken.

We should not discount the burden of drug costs on those who are acutely ill. Although only a few will be affected by the immunosuppressant drug benefit in current law, the drugs are very expensive. The Congressional Budget Office estimates that the costs of providing immunosuppressant drugs to 9000 Medicare beneficiaries with kidney transplants will approach $35 million in 1987 (or about $4000 per transplant beneficiary). Restricting any new drug benefit to the expansion of immuno-suppressants would constitute only a very minor improvement in Medicare coverage.

Some Medicare beneficiaries could avoid hospitalization or be discharged earlier if certain drug therapies were covered on an outpatient basis. For example, recent studies suggest that Medicare hospital expenditures could be reduced significantly through coverage of at-home antibiotic infusion for several categories of Medicare patients (i.e. those suffering from diseases such as osteomyelitis, endocarditis, and cellulitis which typically require a several-week course of intravenous antibiotics). This limited expansion of the Medicare benefit could be made now, even in the absence of additional funding.

State Efforts

Currently eight states have implemented programs to cover outpatient drugs for elderly residents who meet eligibility

requirements. New York, the ninth state, will begin coverage for its plan starting this October.

All programs have differing co-pays and eligibility requirements, but basically all serve to cover marginally poor older persons whose incomes are too high to qualify for Medicaid. AARP believes that Congressional efforts to implement a drug benefit program for the elderly under Medicare would be enhanced by studying these successful state programs. We conclude that these programs demonstrate the feasibility of providing drug coverage under Medicare.

For example, the Pennsylvania system, PACE (Pharmaceutical Assistance Contract for the Elderly), was started in 1984 and now has 458,000 enrollees. PACE covers all drugs that are available by prescription only. In their first two and one-half years of operation, PACE provided $234 million in benefits and spent only $15.5 million (about 6 percent) on administrative costs. Two categories of drugs, cardiac and gastrointestinal, account for 60 percent of the PACE budget.

AARP Recommendations

AARP recommends a Medicare prescription drug benefit that would provide meaningful coverage to beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include:

- A deductible no higher than $500 per year with a minimal or no coinsurance payment;
- Continuation of Medicare's existing prescription drug benefit; and
- Medicaid coverage of individuals up to 100 percent of the federal poverty level.
- Further, we recommend that the beneficiary deductible and coinsurance payments be counted toward the total catastrophic cap.

Little data exists on the potential utilization of a full Medicare prescription drug benefit, its cost, or its administration. AARP recognizes the seriousness of these considerations and, therefore, is proposing a benefit that is fiscally responsible, administratively manageable, a source of useful data, and, most importantly, a benefit of real value. Accordingly, our recommendations for implementation and financing are as follows.

Cost Containment

Cost containment mechanisms and systems to encourage generic substitution of equivalent drugs are essential to any program that seeks to implement or expand a prescription drug benefit.

Pricing and Reimbursement

A fair pricing mechanism should be developed which allows for reasonable profits for manufacturers and reasonable dispensing or administrative fees for providers of pharmacy services.

We should look to the rather unsuccessful experience in the MAC/EAC (Maximum Allowable Cost/Estimated Acquisition Cost) program for Medicaid prescription drug reimbursement to avoid a similar experience. Under MAC/EAC, reimbursement limits to pharmacists were set for a number of multiple and single-source drugs. These limits did not take into account the frequent and sharp rises in prices for drugs at the manufacturers' level and therefore, the burden of this difference fell solely on the pharmacists. We believe that the impact of cost containment strategies should be shared by the manufacturer. Recent Congressional hearings have focused attention on price increases at the drug manufacturers' level, which have skyrocketed out of proportion to the overall inflation rate and show no signs of abating.

It is generally accepted that in the single-source drug market there is neither rhyme nor reason in pricing policies. Virtually every country except the U.S. employs some mechanism to control prescription drug prices. AARP recommends implementing a reimbursement system for single-source drugs similar to systems that operate in many countries whereby manufacturers submit data on manufacturing costs, research and development expenditures and other factors that relate to the costs associated with a new drug product. Reimbursement rates for individual products are then calculated to include other factors such as reasonable advertising and promotional expenditures.

We recognize that traditionally, the U.S. market has been vital to drug manufacturers in recouping the costs of bringing new drugs on the market. Consequently, we do not wish to peg or target reimbursement at the same absolute level as some other countries, many of which are especially austere.

For multiple-source drugs, market factors should prevail and reimbursement could be set as a reasonable percentage of the lowest-priced equivalent product that is generally available to all pharmacy outlets. Alternatively, reimbursement levels could be pegged at the median average wholesale price (AWP) for all equivalent products, with the pioneer product's price serving as the highest price considered. Another approach would set the multiple-source product reimbursement limit at 50% of the brand product's AWP as listed in January, 1987.

Administration

Administration of the benefit would employ the concept of participating pharmacies. Beneficiaries would enroll with a participating pharmacy or pharmacies each year. Pharmacies would batch claims by individual beneficiaries and submit them together when the deductible has been met. Beneficiaries themselves could batch claims and bill Medicare directly if desired. Conditions of participation by pharmacies should not restrict any current providers of pharmacy services who wish to participate.

Timeline

The benefit should be phased-in over a period of several years to allow for proper implementation mechanisms to be put into place.

Financing

The benefit would be financed through a premium and by bringing all state and local employees into Medicare.

The high deductible in this benefit and inclusion of the deductible and coinsurance in the overall catastrophic cap are compatible with the principle of catastrophic coverage. The minimal coinsurance would offer a beneficiary significant relief when the deductible is reached. In addition:

- The approach we propose is more equitable than drug specific approaches in that it covers both medication needed by patients with chronic conditions and the very high cost of medication needed for treatment of acute care conditions.
- Because the benefit covers the full range of prescription drugs, it can be used to develop data on utilization (types of drugs prescribed/price) by those who meet the deductible.

- The benefit would be easy for beneficiaries and physicians to understand, since coverage is not based on specific types or classes or drugs prescribed.

Implementation of the benefit we propose would yield information about utilization levels, cost and cost-containment, and administration. If actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200.

Conclusion

We hope that 1987 will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will still have far to go in protecting the nation against some of the most burdensome health care costs. But in the area of prescription drugs we can take steps this year to provide a benefit that is fiscally sound and administratively manageable. AARP applauds the leadership of this committee in addressing this issue.

We look forward to working with you to achieve passage of the Medicare prescription drug benefit and urge you to call on us for any information we can provide.

TABLE 1

Rx DRUG COSTS EXAMPLE

Even if one is not catastrophically ill, one can incur rather catastrophic prescription bills. The example below is of a relatively healthy older person who suffers from four common, but chronic conditions: arthritis, high blood pressure, angina and an ulcer. All drugs listed are commonly prescribed but also newer drugs so that generic copies are not yet available.

		Price per 100 at AARP Pharmacy
Diagnosis:	Arthritis	
Treatment:	Feldene (piroxicam) 20 mg. q.d.*	$102.45
Diagnosis:	Hypertension (high blood pressure)	
Treatment:	Dyazide (triamterene & HCT) 1 cap. q.d.	$ 19.65
	Tenormin (atenolol) 50 mg. q.d.	$ 39.15
Diagnosis:	Angina (heart pain)	
Treatment:	Procardia (nifedipine) 10 mg. t.i.d.	$ 24.45
Diagnosis:	Ulcer	
Treatment:	Tagamet (cimetidine) 300 mg. (q.i.d for 6-8 weeks, then 300 mg. q.d.)	$ 39.95

Occasional use of over-the-counter preparations:
Metamucil
Milk of Magnesia

Daily prescription drug costs: $ 3.93 (for 2 months, then $2.73/day)
Monthly prescription drug costs: $117.90 (for 2 months, then $81.90/month)
Yearly prescription drug costs: $1,054.80

Note: Dosages listed are conservative. Prices are also on the conservative side since the AARP Pharmacy is both not-for-profit and buys in large quantities. Prices are accurate as of October 1986.

*q.d. - once a day
t.i.d. - three times a day
q.i.d. - four times a day

TABLE 2

PREVALENCE OF TOP CHRONIC CONDITIONS

AMONG OLDER AMERICANS

Condition	Total persons 65 years and older	Rate per 1000 persons for those 65 years & older
Arthritis	11,547,889	464.7
Hypertensive disease	9,406,958	378.6
Hearing impairments	7,051,238	283.8
Heart Conditions	6,883,416	277.0
Chronic sinusitis	4,562,037	183.6
Visual impairments	3,395,397	136.6
Orthopedic impairments	3,185,565	128.2
Arteriosclerosis	2,410,125	97.0
Diabetes	2,073,037	83.4
Varicose veins	2,067,311	83.2
Hemorrhoids	1,637,487	65.9
Frequent constipation	1,471,915	59.2
Disease of urinary system	1,395,187	56.1
Hay fever	1,290,449	51.9
Corns and callosities	1,289,933	51.9
Hernia of abdominal cavity	1,220,156	49.1

Source: "DataWatch", Health Affairs, Spring 1985.

TABLE 3

PERCENT DISTRIBUTION OF PRESCRIPTIONS BY THERAPEUTIC FUNCTION FOR AGED NON-INSTITUTIONALIZED MEDICARE BENEFICIARIES

(1980)

1.	Cardiovascular/Renal	39.4%
2.	Pain Relief	11.3
3.	Affecting Nervous System	8.3
4.	Hormonal Agents/Hormones	7.3
5.	Respiratory/Allergy	7.0
6.	Gastrointestinal	5.6
7.	Homeostatic/Nutrient	5.0
8.	Antimicrobial	4.9
9.	Ophthalmological	3.1
10.	Others	8.1

Source: LaVange, Lisa (Research Triangle Institute) and Herbert Silverman (HCFA), "Prescription Drug Utilization and Expenditure Patterns of Aged Medicare Beneficiaries", Draft Report NMCUES Series (in press), September, 1984.

The CHAIRMAN. Thank you very much, Mr. Stallworth.

First of all, do you recommend means testing?

Mr. STALLWORTH. No, sir, AARP does not. And if you don't mind, I'd like for Ms. Brown to speak to that issue.

The CHAIRMAN. All right, Ms. Brown.

Ms. BROWN. We think that the poor should certainly have the drug benefit paid for them by Medicaid coverage for those persons living at up to 100 percent of the Federal poverty level. But we think that all Medicare beneficiaries, regardless of income, should be entitled to the same benefit.

The CHAIRMAN. Therefore, you want more Medicaid patients to be eligible for it?

Ms. BROWN. Since the prescription drug benefit is paid by premiums, we want the premiums and co-pays for those who are poor to be paid by Medicaid. Everyone else who is a Medicare beneficiary who happens to have catastrophic drug costs over whatever the deductible is set at—we hope it's $500 a year, no higher than that—would be entitled to the benefit. They wouldn't have to have a specific means test to be entitled to the drug benefit, just the fact that they have spent a certain amount for outpatient prescription drug bills in any given year.

The CHAIRMAN. Well, what about the States which don't permit Medicaid beneficiaries to have their prescription drugs paid for?

Ms. BROWN. The States are all over the map on what Medicaid will or will not provide pay for. Some States have taken it upon themselves to provide for the marginally poor elderly who do not qualify for Medicaid, and we certainly support those State efforts to help people pay for prescription drugs. However, what we'd like to see is the Federal poverty level be the standard for all States under this program. Those poor people that are under the Federal poverty level, 100 percent of it, would have their premiums and co-pays paid.

The CHAIRMAN. Not at 125 percent, but at 100 percent of the poverty level?

Ms. BROWN. We recommend 100 percent of the poverty level at this time.

The CHAIRMAN. Then anything under that would be a Federal responsibility through Medicaid?

Ms. BROWN. A Federal and State responsibility—yes.

I would have to get back to you if you would like more information on the technical aspects of how the Medicaid program in the States and their variability would interplay with the Federal program. Generally, however, we would like poor people to have their costs covered; and those people with high out-of-pocket expenses for drugs who are Medicare beneficiaries, not because of any means test, but because they've incurred catastrophic expenses—should be entitled to benefit from the prescription drug plan.

The CHAIRMAN. And then for the rest of the people, prescription drugs coverage would be financed through a premium?

Ms. BROWN. Yes—well, the premium would basically finance everybody.

The CHAIRMAN. The premium would finance everybody, but not Medicaid?

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Ms. BROWN. Yes, you're correct. There are provisions to link State Medicaid programs to the Federal Medicare catastrophic provisions and financing varies a bit there.

The CHAIRMAN. And Mr. Stallworth, do you have an estimate on what that premium would be? I think you ended up saying you hoped it wouldn't be over $200.

Mr. STALLWORTH. Yes, there are estimates. I think the $200 you are referring to is what AARP hopes the deductible will be able to be reduced to in time.

Ms. BROWN. CBO has an estimate and HCFA has an estimate, and they will be testifying later. We prefer to let those responsible for the official estimates speak for themselves. They certainly have been part of our calculations, but we have been more concerned today about documenting the need for the program as opposed to the more technical aspects of how it will be structured.

The CHAIRMAN. And it would have a deductible?

Ms. BROWN. Yes. In fact, an additional co-insurance is not altogether objectionable to us. We think that co-insurance, in the form of a percentage of the cost, can be important in helping to keep down program costs because it encourages the consumer to be a more prudent purchaser in that they would have to pay a certain percentage of the bill. That would encourage generics, for example, over a brand name drug where the brand product is not medically necessary.

The CHAIRMAN. All right. And you believe it's time to act? That's the final question.

Ms. BROWN. Absolutely. Bottom line.

The CHAIRMAN. Thank you both very much.

Ms. BROWN. Thank you.

The CHAIRMAN. We appreciate your testimony.

We have a statement prepared by Mr. Walton Francis, who is Director, Division of Policy Analysis and Regulatory Review from the Department of Health and Human Services.

STATEMENT OF WALTON FRANCIS, DIRECTOR, DIVISION OF POLICY ANALYSIS AND REGULATORY REVIEW, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. FRANCIS. With your permission, Mr. Chairman, we have submitted a complete statement for the record. I would like to summarize it for you and hit the high points.

The CHAIRMAN. Please proceed. Your prepared statement will appear in the record immediately following your oral presentation.

Mr. FRANCIS. Mr. Chairman, thank you for the opportunity to discuss the Administration's views on Medicare coverage of prescription drugs, and more specifically, on whether prescription drug benefits should be included in the catastrophic protection legislation.

I am filling in today for our Assistant Secretary for Legislation, who had hoped to be here to present testimony on this issue, a subset of your hearings on the larger issue of prescription drugs and the elderly in general.

The Administration strongly believes that catastrophic health care legislation should provide acute care protection for the elderly

against catastrophic health events. Expansions to Medicare unrelated to this should not be included in a catastrophic bill. In what follows, I will focus on issues of need, financing, and administrative costs.

Almost all elderly citizens use prescription drugs. However, drug expenses do not usually represent catastrophic costs. For those who spend the most, these costs are often picked up by other insurance, such as Medicaid, or Medigap policies for those who don't have Medicaid. Furthermore, proposals to restructure Medicare would alleviate most of the residual out-of-pocket liability. Beneficiaries who incur significant costs for drugs are usually those who have high costs for other Medicare-covered services. Therefore, adding a catastrophic "stop loss" provision to current Medicare benefits would greatly reduce the burden of drug expenses.

According to our actuaries, preliminary estimates of the various drug proposals under consideration have been severely understated. Our own estimates are that the major prescription drug proposals offered in the House of Representatives would cost from $5 billion to $8 billion by 1989. Ongoing administrative costs could exceed $500 million a year. This would be approximately 7 percent of the benefits paid out under this program expansion. Thus, the drug benefit is very costly to administer compared with other Medicare services, for which administrative costs average 1.3 percent of service costs.

We have analyzed the various proposals in the House and we estimate that, for prescription drugs alone, the premium increase would range from $15 to $24 per month the first year. This is added to the basic Part B and catastrophic premiums. The initial cost to the beneficiary, we feel, would be overwhelming. We cannot help but point out that some critics denounced the Part B premium increase already proposed by the Administration as being unaffordable. It is one-fourth the cost of the premium we are discussing today.

It is also doubtful that costs of this magnitude could be designed into a self-financing benefit package which would stay budget-neutral over time.

I would like to turn now to the question of our ability to administer a program as complex as drug coverage.

We believe the administrative problems would be immense. Much further analysis is required before we could even recommend an appropriate strategy. Foremost among the problems of designing and implementing a Medicare drug benefit is determining which drugs are to be paid for and how much one should pay for their coverage. A difficult choice would need to be made between covering all drugs requiring prescription, or establishing a Federally-prescribed formulary, a list of drugs that Medicare will or will not cover. While a formulary may seem desirable in terms of limiting the benefit to cost-effective drug products, the administrative process and political controversy entailed in distinguishing among these products could outweigh any benefit savings. Yet, without a formulary, program costs would rise because of inevitable substitution effects. Such medications as vitamins and skin ointments, now sold as over-the-counter remedies, would surely decline and be replaced by prescribed forms of these medications.

We all want Medicare to get the best possible deal for its dollars while paying a fair amount. To accomplish this, however, even more work would be necessary. HCFA would have to do extensive surveying, data-gathering and auditing to assure our beneficiaries, who would be paying for this coverage, that they are getting the best possible deal.

You should be aware that, ultimately, the result could be to move Medicare in the direction of administered pricing.

Regardless, a new drug benefit would necessitate the establishment of a complex and costly claims processing system. Depending on its design, Medicare may have to process as many as 300 million claims per year and monitor about 67,000 pharmacies.

As I indicated earlier, the ongoing costs for administering a drug benefit would be in the range of one-half billion dollars a year. Since an average drug claim would only be $10 to $20 in 1989, the ratio of administrative costs to benefit costs would be very high. We estimate that the average per-claim cost to Medicare, primarily for claims processing, would be about $1.72 per claim. This does not include the additional costs of audits, medical review, and other administrative tasks.

To reduce the number of claims that HCFA would process, one suggested approach that we have heard advanced would be to institute the concept of "participating pharmacies." This would not only create confusion on the part of beneficiaries, but significant resources would be required to audit the benefit to ensure that claims were submitted only for valid prescriptions. Under this approach, pharmacists would have to keep comprehensive records that would stand up to post-adjudicative audits. Since pharmacies would be required to keep track of individual beneficiary drug expenses, their costs would be substantial. Only 13 to 19 percent of beneficiaries might meet the deductible, so eventual billing and payment to the pharmacy for its effort would be limited.

Pharmacists may be willing initially to accept a set administrative allowance of, say, $4.50, which has been suggested. However, they might later expect to receive a higher amount, especially if payment for product costs is tightened. Moreover, not all pharmacies have the capacity for electronic recordkeeping or mail claims. Only about 40 percent do, and they tend to be the larger pharmacies.

Another approach would be to require Medicare beneficiaries to hold their drug bills until they reach the deductible, and then submit them to Medicare. While this would reduce the number of separate transactions, all of the other time-consuming problems of screening for eligible drugs, applying cost limits, and so forth would remain. Furthermore, maintaining such records would be a burden on some persons of advanced age or infirmity.

In conclusion, Mr. Chairman, the Department of Health and Human Services recently spent over a year analyzing approximately 50 different proposals for catastrophic health insurance programs. In the end, the President decided on a plan which would provide peace of mind and which would be affordable to both taxpayers and beneficiaries. Whether new benefits such as prescription drugs are advantageous or not is a separate question from that of simply and directly adding catastrophic coverage to our Medi-

care program. We do not believe that a catastrophic protection bill is the appropriate vehicle on which to place additional and worrisome costs that may eventually threaten the entire Medicare program.

Secretary Bowen has signaled to the House leadership that inclusion in the legislation of a drug benefit, which—if it could be crafted—would run into billions of dollars in expenditures per year, could cause recommendation of a Presidential veto. I hope the committee will keep these issues in mind as you weigh this serious question.

Mr. Chairman, we appreciate your holding this hearing today and studying a very crucial issue of interest and importance to the elderly in our Nation. It is clear to us that a great deal of study must be devoted to this issue, and your examination today is an important step in that process.

Thank you.

[The prepared statement of Mr. Francis follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

STATEMENT BY

WALTON FRANCIS

DIRECTOR, DIVISION OF POLICY ANALYSIS
AND REGULATORY REVIEW

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss the Administration's views on Medicare coverage of prescription drugs, and more specifically, on whether a prescription drug benefit should be included in catastrophic protection legislation. As you mentioned, I am filling in today for our Assistant Secretary for Legislation, who had hoped to be here to present testimony on this issue, a subset of your hearing on the larger issue of prescription drugs and the elderly in general.

The Administration strongly believes that catastrophic health care legislation should provide acute care protection for the elderly against catastrophic health events. Expansions to Medicare unrelated to this should not be included in a catastrophic bill. The Secretary of Health and Human Services has conveyed to the House leadership that inclusion of an outpatient prescription drug benefit alone could lead to a veto recommendation by the President's senior advisors. The merits of such a benefit expansion are debatable --and this hearing will help foster that dialogue --but it should not be included in a catastrophic bill sent to the President.

Specifically, we should consider the following questions relating to a prescription drug benefit: Is it needed? Is it catastrophic? Would it be self-financing? What would it cost the Medicare program? Is it administerable? Is it appropriate as a Federal Medicare benefit, or is it more appropriately placed in the private sector?

What is the Need for a Prescription Drug Benefit?

Almost all elderly citizens use prescriptions drugs. However, drug expenses do not usually represent catastrophic costs. In fact, we estimate that 50 percent of the elderly will spend less than $175 on drugs in 1989, and 20 percent will spend nothing. For those who spend the most, these costs are often picked up by insurance.

- prescription drugs for low-income beneficiaries are paid for by Medicaid in all but two States; and
- thirty percent of non-Medicaid beneficiaries have Medigap policies with at least some prescription drug coverage.

Futhermore, proposals to restructure Medicare would alleviate most of the residual out-of-pocket liability. Beneficiaries who incur significant costs for drugs are usually those who also utilize a great deal of other Medicare services. Therefore, adding a stop-loss feature to current Medicare benefits should serve to reduce the burden of drug expenses.

Would it be Self-Financing?

According to our actuaries, preliminary estimates of the various drug proposals under consideration have been severely understated. Our estimates are that the major prescription drug proposals offered in the House of Representatives would cost from $5.28 to $8.4 billion -- that's with a "b" -- in 1989. Ongoing administrative costs could range from $470 to $577 million, approximately 7 percent of the benefits paid out under this program expansion. Thus, a drug benefit is very costly to administer, compared with other Medicare services, for which administrative costs average 1.3 percent of service costs.

We have analyzed the various proposals in the House and we estimate that, for prescription drugs alone, the premium would range from $15 to $24 per month the first year. This is added to to the basic part B and catastrophic premiums.

The initial cost to the beneficiary, we feel, would be overwhelming. I cannot resist pointing out that some critics denounced the part B premium proposed by the Administration as being unaffordable. It is one-fourth the cost of the premium we are discussing today.

It is doubtful that costs of this magnitude could be designed into a self-financing benefit package. Even if five-year estimates could show it to be budget-neutral, there would be, no doubt, a tendency at some future time to look toward general revenues to subsidize the benefit, rather than increase the beneficiary's premium to keep pace with inflation. Consequently, the Medicare program would be at risk for continuing a high cost benefit package.

I would like to turn now to the question of our ability to administer a program as complex as drug coverage.

Administration

We believe the administrative problems would be immense. Much further analysis is required before we could even recommend an appropriate strategy.

There are a number of significant issues I would like to highlight for the Committee:

o Payment and Coverage

Foremost among the problems of designing and implementing a Medicare drug benefit is determining which drugs are to be paid for and how much one should pay for their coverage.

A difficult choice would need to be made between covering all drugs that require a prescription and establishing a Federally prescribed formulary. A formulary could be either a list of drugs that Medicare will cover -- a positive formulary -- or a list of drugs that Medicare will not cover -- a negative formulary. While a formulary may seem desirable in terms of limiting the benefit to cost-effective drug products, the administrative process and political controversy entailed in distinguishing among these products could outweigh any benefit savings.

Without a formulary, other significant problems would arise. First, would be the issue of program costs. Any prescribed drug approved by the Food and Drug Administration such as antibiotics and cough medicine would be covered under Medicare, including drugs used only episodically for short-term illnesses. Second, another adverse consequence would likely occur without a formulary because of inevitable substitution effects. Such medications as vitamins and skin ointments now sold as over-the-counter remedies would surely decline and be replaced by prescribed forms of these medications.

We all want Medicare to get the best possible deal for its dollars while paying a fair amount. To accomplish this, however, more work would be necessary. HCFA would have to do extensive surveying, data gathering, and auditing to assure our beneficiaries, who would be paying for this coverage, that they are getting the best possible deal.

You should be aware that, ultimately, the result could be to move Medicare in the direction of administered-pricing.

o Claims Processing

A new drug benefit would necessitate the establishment of a complex and costly administrative system. Depending on its design, Medicare may have to process as many as 300 million claims per year and monitor about 67,000 pharmacies. As I indicated earlier, the ongoing costs for administering a drug benefit would be significant.

Since an average drug claim will be only $10 to $20 in 1989, the ratio of administrative cost to benefit cost would be very high. We estimate that the average per-claim cost to Medicare, primarily for claims processing, would be $1.72. This does not include the additional costs of audits, medical reviews, and other administrative tasks. Total start-up costs would be about $110 million.

o Participating Pharmacists

To reduce the number of claims that HCFA would process, one suggested approach we have heard advanced would be to institute

the concept of "participating pharmacies." This would not only create confusion on the part of beneficiaries, but significant resources would be required to audit the benefit to ensure that claims were submitted only for valid prescriptions. Under this approach, pharmacists would have to keep comprehensive records that would stand up to post-adjudicative audits. Since pharmacists would be required to keep track of individual beneficiary drug expenses, their costs would be substantial. Only 13 to 19 percent of beneficiaries might meet the deductible, so eventual billing and payment to the pharmacy for its effort would be limited. Pharmacists may be willing, initially, to accept a set administrative allowance of, say, $4.50, which has been suggested. However, given their increased record-keeping burden, they might soon expect to receive a higher amount, especially if payment for product costs are tightened.

Coordination of records to keep track of beneficiary expenses is also an important issue. It would be especially complicated for beneficiaries who use more than one participating pharmacy. Not all pharmacies have the capacity for electronic mail claims. In fact, only 40 percent do, and they tend to be the larger pharmacies. Clearly, pharmacies in rural areas do not generally have this capability.

The alternative to the participating pharmacy concept is for beneficiaries to submit claims directly to Medicare. Medicare would then have to process hundreds of millions of additional claims, most of which would not be eligible for payment. In addition, based on our experience, we would expect that many of the claims would be submitted with incomplete information. Beneficiary dissatisfaction with this process would be noticeable, since only a few of the claims submitted would be eligible for payment.

Another approach would be to require Medicare beneficiaries to hold their drug bills until they reach the deductible, and then submit them to Medicare. While this would reduce the number of separate transactions, all of the other time consuming problems of screening for eligible drugs, applying cost limits, and obtaining missing information would remain. Further, maintaining

the record system would be a burden on some persons of advanced age or infirmity.

CONCLUSION

Mr. Chairman, as you are aware, the Department of Health and Human Services recently spent over a year analyzing approximately 50 different proposals for a catastrophic health insurance program. In the end, the President decided on a plan which would provide peace of mind, and which would be affordable to both taxpayers and beneficiaries. Whether new benefits such as prescription drugs are advantageous or not is a separate question from that of simply and directly adding catastrophic coverage to the Medicare program. We do not believe that a catastrophic protection bill is the appropriate vehicle on which to place additional and worrisome costs that will eventually threaten the entire Medicare program. Secretary Bowen has signaled to the House leadership that inclusion in the legislation of a drug benefit, which -- if it could be crafted -- would run into billions of dollars in expenditures per year, could cause recommendation of a Presidential veto. I hope the Committee will keep this in mind as you weigh this issue.

Mr. Chairman and Members of the Committee, we appreciate your holding this hearing today and studying a very crucial issue of interest to the elderly in our Nation. It is clear to us that a great deal of study must be devoted to this issue, and your examination today is an important step.

Thank you.

The CHAIRMAN. Thank you, Mr. Francis.

I believe it is fair to say that while the Department may not be ready to act on the high costs of prescription drugs, I believe Congress is ready. And the reason Congress is ready is because of the literally millions of constituents who have told us, all 535 of us—100 in the Senate and 435 in the House—that this is really what's affecting them the most. They are shocked to learn that as they get into their retirement years, what they thought would be covered or assisted by Medicare is not.

More and more people are saying that Medicare doesn't have the right kind of program for us. We in Congress are beginning to respond to that.

I think we've had a lot of studies and people are ready now for prescription drug coverage, it's up to us here in Congress to find out how to provide it, and how to pay for it.

Thank you very much.

Mr. FRANCIS. Thank you, sir.

The CHAIRMAN. Dr. Raymond Scalettar?

Dr. Scalettar is a Board Member of the American Medical Association. Doctor, please proceed.

STATEMENT OF RAYMOND SCALETTAR, M.D., BOARD MEMBER, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DEPARTMENT OF FEDERAL LEGISLATION

Dr. SCALETTAR. Mr. Chairman, thank you very much.

Mr. Chairman, I am Raymond Scalettar, M.D. I am a physician in the practice of internal medicine in Washington, D.C. I am also a member of the Board of Trustees of the American Medical Association. Accompanying me is Bruce Blehart of the American Medical Association's Department of Federal Legislation. The AMA is pleased to have this opportunity to testify concerning expansion of Medicare to cover outpatient prescription drugs.

Prescription drugs are essential in providing quality patient care, particularly for senior citizens. Prescription medicines are often the most effective treatment regimen and can be the most cost-effective.

While many Medicare beneficiaries have drug coverage available through Medigap policies or other coverage plans, the majority are not currently so protected. As a result, many Medicare beneficiaries incur significant and potentially catastrophic out-of-pocket expenses for outpatient prescription medications. As you have heard today, this also may prove catastrophic in a real medical sense if patients do not fill prescriptions or take medications according to instructions because of cost.

Due to the health benefits of prescription drug use and the severe financial burden such drug costs may place on some beneficiaries, proposals to provide coverage for outpatient drug costs deserve careful consideration.

It is well established that a drug product may be effective and safe for one patient but may not be the drug of choice for another patient. In order to assure optimal success in treatment, physicians and their patients must have available to them the full range of drugs from which to choose and the freedom to be able to prescribe

and use the drug that, in the professional judgment of the physician, is most appropriate for the patient.

The AMA vigorously opposes the establishment of a national or State drug formulary or other mechanism to restrict drug availability. Restricting the availability of certain drugs would have a detrimental effect on patient care.

For Medicare drug coverage to be affordable, it is important that the benefit be limited to truly catastrophic costs. To accomplish this, any legislation should provide for a reasonable deductible. In addition, if the deductible is set at a relatively low level, we would support reasonable beneficiary co-insurance for this benefit.

We believe strongly that the premiums should be means-related. Relating a premium, deductible or co-insurance to the beneficiary's financial resources would guarantee that those elderly who can afford to pay more for the drug benefit would do so. It is important to recognize that the elderly do have different levels of resources and that the needy elderly should not be denied benefits in order to maintain equal costs among all beneficiaries.

Mr. Chairman, we want to emphasize one additional point. The continued development of and research into new and innovative drug therapies is extremely important to quality patient care. Under no circumstances should a catastrophic drug benefit program operate in such a way as to discourage this essential research and development. Failure to recognize and maintain the benefits from continued drug development would be both short-sighted and counterproductive.

In conclusion, Mr. Chairman, the AMA supports the inclusion of outpatient prescription drug coverage as a part of a program to provide catastrophic coverage if the drug benefits are tailored along the lines we have described.

We stand ready to assist the committee in any way that we can. I will be happy to answer any questions you may have.

[The prepared statement of Dr. Scalettar follows:]

Statement of the American Medical Association

to the

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

Presented by

Raymond Scalettar, M.D.

RE: Catastrophic Drug Benefits

July 20, 1987

American Medical Association
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Department of Federal Legislation
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STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

Presented by

Raymond Scalettar, M.D.

RE: Catastrophic Drug Benefits

July 20, 1987

Mr. Chairman and Members of the Committee:

My name is Raymond Scalettar, M.D., and I am a physician in the practice of Internal Medicine in Washington, D.C. I am also a member of the Board of Trustees of the American Medical Association. Accompanying me is Bruce Blehart of the AMA's Department of Federal Legislation. The AMA is pleased to have this opportunity to testify concerning expansion of Medicare to cover outpatient prescription drugs.

Prescription drugs are a vitally important element in providing quality patient care, particularly for senior citizens. Prescription medicines are often the most effective treatment regimen and can be the most cost-effective. The availability and use of proper medications often reduce the need for other more expensive and/or invasive types of therapy such as surgery.

While many Medicare beneficiaries have drug coverage available through Medigap policies or other coverage plans, the majority are not currently so protected. Approximately 60% of Americans over age 65 lack insurance coverage for outpatient prescription drugs. As a result, many Medicare beneficiaries incur significant and potentially catastrophic out of pocket expenses for outpatient prescription medications. This also may prove catastrophic in a real medical sense if patients do not fill prescriptions because of cost.

Due to the health benefits of prescription drug use and the severe financial burden such drug costs may place on some beneficiaries, the AMA believes that proposals to provide coverage for outpatient prescription drug costs deserve careful consideration by Congress. To be truly beneficial, any such legislation should meet the following principles:

- the full range of prescription drugs must be available to the patient;
- the patient's physician must be allowed to prescribe the drug of choice that, in his or her professional judgment, is deemed most appropriate for the patient;

- o the bill must not include a formulary that would limit the availability of drugs;
- o the program should provide for a reasonable deductible, and coinsurance may also be desirable if the deductible is set at a relatively low level;
- o the premium, deductible or coinsurance should be related to the beneficiary's financial resources in order to ensure that the program is not too expensive for lower income beneficiaries; and
- o in view of the serious budget constraints, a Medicare outpatient drug program should be budget neutral.

Prescription Drug Availability

It is well established that a drug product may be effective and safe for one patient but may not be the drug of choice for another patient. In order to assure optimal success in treatment, physicians and their patients must have available to them the full range of drugs from which to choose and the freedom to be able to prescribe and use the drug that, in the professional judgment of the physician, is most appropriate for the patient.

The AMA vigorously opposes the establishment of a national or state drug formulary or other mechanism to restrict drug availability. Restricting the availability of certain drugs would have a detrimental effect on patient care.

Reasonable Deductible and Coinsurance

For Medicare drug coverage to be affordable, it is important that the benefit be limited to truly catastrophic costs. To accomplish this, any legislation should provide for a reasonable deductible. In addition, if the deductible is set at a relatively low level, we would support reasonable beneficiary coinsurance for this benefit. H.R. 2470, the House Medicare catastrophic coverage bill that also provides coverage for prescription drugs, sets a deductible of $500 with coinsurance at 20%.

Financing

In view of the massive federal budget deficit and the serious financial problems of the Medicare program, it is essential that any new benefit be budget neutral. Drug prices along with the number of prescriptions written and dispensed are likely to rise in future years. In order to ensure that all new benefits are completely and adequately funded through new revenues, the premium for prescription drug coverage should be adjusted annually either upward or downward.

Income-Related Premium, Deductible or Coinsurance

We believe strongly that the program should be means-related. Relating a premium, deductible or coinsurance to the beneficiary's financial resources would guarantee that those elderly who can afford to pay more for the drug benefit would do so. This would ensure that the program is within reach of lower income beneficiaries. Exempting

beneficiaries with incomes below a certain level from being liable for a premium should also be considered. It is important to recognize that the elderly do have different levels of resources and that the needy elderly should not be denied benefits in order to maintain equal costs among all beneficiaries.

Other Issues

Mr. Chairman, other issues need to be resolved before Medicare is expanded to cover the catastrophic costs of outpatient prescription drugs. For example, concerns have been raised by the Administration about the administrative costs and complexities of such a program. In fact, Secretary Bowen has alleged that the administrative costs alone would exceed a half-billion dollars per year. We recommend that any drug benefit program should be designed to be as administratively simple as possible in order to keep costs relatively low and realistic in relation to the benefit.

Mr. Chairman, we want to emphasize one additional point. The continued development of and research into new and innovative drug therapies is extremely important to quality patient care. Under no circumstances should a catastrophic drug benefit program operate in such a way as to discourage this essential research and development. Failure to recognize and maintain the benefits from continued drug development would be both short-sighted and counterproductive.

Conclusion

In conclusion, the AMA supports the inclusion of outpatient prescription drug coverage as a part of a program to provide catastrophic coverage if the drug benefits were tailored along the lines we have described.

Mr. Chairman, the AMA commends the Committee for its interest in this important health issue. We stand ready to assist the Committee in any way we can. I will be happy to answer any questions you or other Members of the Committee may have.

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The CHAIRMAN. Doctor, AMA believes that there should be a means test?

Dr. SCALETTAR. Yes, sir, that's correct.

The CHAIRMAN. No matter how we say it—means-related or income-related—we're talking about looking at what the situation is. And if the people cannot afford it, or have to forgo other essentials of life, we ought to have a mechanism that pays for those prescription drugs.

Dr. SCALETTAR. We heard very compelling testimony today, sir, and we know that there are individuals who can't afford to pay for their drugs and their medications. There are those who are needy—the poor and the near-poor that we heard of today—we have to have compassion for these people and recognize their plight.

The CHAIRMAN. Well, I think that's correct, and I believe that to provide older Americans with the type of health care they need, we're going to have to consider using some type of income-based benefit.

AARP, the American Association of Retired Persons, does not advocate means-testing. However, I do find that an increasing number of people, both in Congress and among older Americans groups, are now changing their attitudes and saying that this is the only way we're going to be able to pay for needed benefits.

I want to commend you, Doctor, and the AMA for what I believe to be very pertinent and very pointed and constructive testimony on this matter. I have looked through your entire testimony; while it is relatively short, I think you have covered the issues that are of significance, and have given us rather apt guidance on how we should proceed on this matter.

I want to thank you very much.

Dr. SCALETTAR. Thank you very much, Senator.

The CHAIRMAN. Dr. John Schlegel, President, American Pharmaceutical Association. Please proceed, Doctor.

STATEMENT OF JOHN SCHLEGEL, PHARM.D., PRESIDENT, AMERICAN PHARMACEUTICAL ASSOCIATION

Dr. SCHLEGEL. Good afternoon, Mr. Chairman. We have submitted more lengthy and comprehensive testimony; I will abbreviate it, hitting the high points, but I'll start off by commending you on selecting a hearing witness list that certainly has brought forth the critical issues related to this emerging problem in our society.

Our testimony focuses on three major points: the issue of patient compliance with treatment and the economic and social factors which influence it; the central importance of pharmaceutical services and prescription drug products in patient care—this is particularly true, as we have heard this morning, of the elderly population, and therefore, coverage for those services and products in any Federal health care initiative is of fundamental importance to us; and finally, the role of the pharmacist in the areas of rational drug use, compliance, and therapy monitoring. This role serves both patients and the health care system in promoting cost-effective drug therapy.

As the committee is well aware, the Nation's elderly population, which is steadily increasing, is the major consumer of health care services. Just to reiterate a few points that you've heard this morning, those over 65 years of age are consuming slightly over 30 percent of the Nation's prescription medications, yet they only represent 12 percent of the population. One projection of drug expenditures for the elderly indicated that $9 billion was spent for prescription medications last year, with $7.3 billion—or about 81 percent—being paid directly by the patient.

A recent study has shown that 15 percent, conservatively, of the elderly population take four or more medications concurrently.

And finally, it is estimated that 70 percent of the medications prescribed for the elderly are for chronic therapy, and that one-third of the elderly population have more than one chronic disease.

These and other data with which the committee is familiar amply demonstrate the central role played by drug therapy in the care of elderly patients.

As the health care system's most readily-accessible professional, the pharmacist has always played an important role in the care of the elderly. We have a long-standing interest in cost containment going back into the 1970's when APHA led repeal of the restricted State anti-substitution laws, thus allowing pharmacists to work with physicians and patients to select the least-costly prescription drug.

Also, pharmacists play a pivotal role in the drug regimen review process, or the review of the patient's medical record for drug-related problems, therapeutic duplications, significant drug interactions, and inappropriate or unnecessary therapy. The Federal Government already recognizes pharmacists as the health professional responsible for drug regimen review and skilled in intermediate care facilities. And as you well know, the primary population of these facilities is the elderly.

Drug therapy is the most common and most cost-effective form of treatment in health care. Effective and rational drug use can serve to forestall the need for expensive inpatient diagnostic and therapeutic services, as we've heard this morning. To artificially separate medical and pharmaceutical services by reimbursing for one and not the other is, in our view, illogical, costly, and just plain foolish.

The committee's focus on compliance is very important. A recent report has estimated that some 100 million prescriptions go unfilled each year. The report further suggests that there are as many as 125,000 Americans that die each year as a result of drug problems, and that perhaps there are as many as 20 million lost work days.

Put simply, better compliance with drug therapy results in reduced costs. One recent study demonstrates this well. Utilization of Medicare services was analyzed in two areas of the northeastern United States. One area has a Pharmaceutical Services Assistance Program, and the other does not. Preliminary data showed that a lower average expenditure for inpatient hospital services occurred in the program which contained the outpatient drug benefit, and the savings more than offset the costs of the drug program. It appears that because medication access for the elderly was facilitated

in the one program, the resulting compliance with the medication regimen resulted in less need for acute inpatient services.

In addition to compliance, better utilization of medications also ultimately results in cost savings. Pharmacy services, such as patient counseling, interaction screening, and computerized record-keeping, constitute the core of effective pharmacy practice in today's use of complex and increasingly dangerous drugs. It's not unusual for a pharmacist to determine that a prescription is either a duplication of current therapy, or will interact adversely with current therapy. The pharmacist will commonly call the prescriber and review the problem, with the possible outcome that the prescription may be voided. Such professional services serve both the patient and third party paying interests. Patients recognize this, for even today in our mobile society data indicate that patients return to the same pharmacy 86 percent of the time.

Rational drug use is not an insignificant issue. Approximately 15 to 20 percent of hospital admissions are related to problems with drug therapy of one type or another.

In summary, Mr. Chairman, we believe that health care is a combination of good medicine and good pharmacy. The services must be supported together to assure good patient care and cost-effective care.

Thank you.

[The prepared statement of Dr. Schlegel follows:]

Statement of the American Pharmaceutical Association

The National Professional Society of Pharmacists

ON

PHARMACEUTICAL SERVICES AND THE ELDERLY

PRESENTED IN CONJUNCTION WITH THE HEARING

HELD BY THE

SENATE SPECIAL COMMITTEE ON AGING

WASHINGTON, DC

JULY 20, 1987

SUBMITTED BY
JOHN F. SCHLEGEL, PHARM.D.
PRESIDENT
AMERICAN PHARMACEUTICAL ASSOCIATION

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
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Mr. Chairman, my name is Dr. John Schlegel. As a pharmacist and President of the American Pharmaceutical Association (APhA), I am pleased to appear before the Special Committee today to share our views on the need for improved prescription drug benefits for elderly Americans. APhA is the national professional society of pharmacists, representing the third largest health profession.

Our testimony today focuses on three major points:

- o The issue of patient compliance with treatment and the economic and social factors which influence it. We applaud the committee for recognizing the major significance of this issue.

- o The central importance of pharmaceutical services and prescription drug products in patient care. This is particularly true of the elderly population. Therefore, coverage for those services and products in any federal health care initiative is of fundamental importance.

- o The role of the pharmacist in the areas of rational drug use, compliance and therapy monitoring. This role serves both patients and the health care system in promoting cost-effective drug therapy.

We recognize and share the concerns about costs, and cost-effectiveness, that members of the Congress have expressed with regard to the care of elderly patients. And we are pleased that pharmaceutical services and prescription drug products are both receiving renewed attention by the Congress, for they represent perhaps the most effective and efficient component of the health care system.

MEDICATIONS AND THE ELDERLY

As the Committee is well aware, the nation's elderly population, which is steadily increasing, is a major consumer of health care services. At the risk of repeating information presented by others, let me point out just a few brief facts:

- o Those over 65 years of age consume slightly more than 30 per cent of the nation's prescription medications, although they represent only 12 per cent of the total population.[1]

- One projection of drug expenditures for the elderly indicated that $9 billion would be spent for prescription medications and services in 1986, with $7.3 billion (81%) being directly paid by the patisnt.[1]

- A study at the University of Michigan College of Pharmacy has shown that 15% of the elderly population take four or more medications concurrently.[2]

- It is estimated that 70% of all medications prescribed for the elderly are for chronic therapy, and that 30-40% of the elderly population have more than one chronic disease.[3]

These and other data with which the Committee is familiar amply demonstrate the central role played by drug therapy in the care of elderly patients.

PHARMACEUTICAL SERVICES

As the health care system's most readily accessible professional, the pharmacist has always played an important role in the care of the elderly. Practices such as counseling on the proper use of medications and potential drug interactions as well as simple, effective services such as home delivery, emergency service and senior citizen reduced fee programs are provided by pharmacists.

Pharmacists also play a pivotal role in the drug regimen review process. This involves the review of the patient's medical record by a pharmacist for drug related problems, therapeutic duplications, significant drug interactions and inappropriate or unncessary therapy. Health Care Financing Administration (HCFA) regulations, which just last month were reissued and strengthened, have reinforced this role. Pharmacists are recognized as the health professional responsible for drug regimen review in skilled and intermediate care facilities. And as you well know, the primary population of these facilities is the elderly.

It is very important to stress that any program which encourages the separation of medical and pharmaceutical services is unwise and potentially costly. Such unbundling of complementary aspects of health care has been done in other programs at great cost to the program and the patient. And the cost I speak of is both a dollar and health status cost. Drug therapy is the most common, and most cost-effective, form of treatment in health care. Effective and rational drug use can serve to forestall the need for expensive inpatient

diagnostic and therapeutic services. Following evaluation by the physician, drug therapy usually serves to "complete the cycle" of the diagnostic and therapeutic process, and it therefore is an integral part of the overall care of the patient. Pharmaceutical services and prescription drug products are an essential complementary aspect to medical services. To artificially separate them by reimbursing for one and not the other is illogical, costly and just plain foolish.

COMPLIANCE/COSTS/ACCESS

The Committee's focus on the components of compliance is very important. It is a central issue in cost-effective health care. A patient stopping an antibiotic after only two or three days because he feels better may experience a relapse, resulting in more expenditures, sometimes even hospitalization. The patient who does not take his high blood pressure medication because he has no symptoms may develop complications requiring hospitalization. A patient with limited resources may decide not to have a prescription filled because the rent has to be paid instead. The consequences can be devastating.

A recent report [4] has estimated that some 100 million prescriptions go unfilled each year. The report further suggests that, overall, medication non-compliance results in the deaths of as many as 125,000 Americans each year, along with thousands of unnecessary hospitalizations and perhaps as many as 20 million lost workdays.

Among many factors which influence compliance, economics and access to services certainly are important. One recent study [5] demonstrates a probable relationship between the availability of medications, compliance and health care costs. The researchers compared the overall rates of utilization of Medicare services in two areas in the northeastern U.S. One area has a pharmaceutical services assistance program and one does not. Preliminary data show that a lower average expenditure for inpatient hospital services occurred in the program which contained the outpatient drug benefit, and the savings more than offset the costs of the drug program. The outpatient drug benefit was the only substantive change in either program during the two study periods. A case can be made that because medication access for the elderly was facilitated in one program, the resulting compliance with the medication regimen resulted in less need for acute inpatient services. Further data in this area will be forthcoming as emphasis on health maintenance and wellness programs increase. We would be happy to provide the Committee with this and other study data in the areas of compliance.

The concerns expressed by many regarding the cost of prescription drugs are valid ones. Increases in the manufacturers' prices of pharmaceutical products in recent years represent the most substantial increase in costs of practice for the pharmacist. We would like the Committee to know that our profession has been actively involved in cost containment strategies for many years. APhA was at the forefront of efforts to repeal restrictive state antisubstitution laws in the 1970's and in promoting the role of the pharmacist in drug product selection. We believe that the pharmacist is the best qualified health care professional to evaluate and use drug product information to assist patients and prescribers in choosing the most rational and cost-effective drug therapy. Often the patient is not aware of this role because the interaction takes place privately between physician and pharmacist. Increasingly, however, this cost saving role of the pharmacist has been experienced personally as patients see pharmacists help them select lower priced drugs.

Government, or any third party program, should provide appropriate economic incentives in order to maximize the pharmacist's participation and effectiveness. The average pharmacy practice operates in an extremely competitive environment, with a net profit before taxes of between 2.5% and 3.5%. In fact competition and increases in the manufacturers' prices of drugs have caused this net profit to decline steadily over the past 10 years. Historical inadequacies in prescription drug reimbursement approaches, both with private and government programs, have often resulted in net loss situations for pharmacists participating in these programs, either reducing incentives to participate or forcing pharmacists to shift their costs to private pay patients. In particular, when the reimbursement focus is primarily on the product cost, with only a token fee for professional service (in some cases as little as $2.00), the pharmacist is not able to cover the costs of service. These services include patient counseling, interaction screening, computerized record-keeping, etc. and constitute the core of effective pharmacy practice in today's use of complex and increasingly dangerous drugs.

Of equal importance, consider the case of a prescription order which the pharmacist determines is either a duplication of current therapy or will interact adversely with current therapy. The pharmacist will commonly contact the prescriber and review the problem, with a possible outcome that the prescription order is voided. Such professional service serves both the patient's interest and the third party payor's interests. Such service occurs

every day in many pharmacy practice settings. Even with today's mobile population, data indicate that patients return to the same pharmacy 86% of the time for prescription services.[4] But clearly the current reimbursement strategies in programs such as Medicaid provide no support for the pharmacist in performing this service, even though the savings associated with avoiding an adverse drug interaction can be substantial. Approximately 15-20 % of hospital admissions are related to problems with drug therapy of one type or another.[5]

Failure to recognize the changing nature and value of the services the pharmacist provides, and therefore a lack of recognition of the need for adequate reimbursement for the services provided beyond the drug product, could have the unfortunate effect of reducing the effective participation of pharmacists in programs being contemplated by the Congress. Such lack of participation would likely impact unfavorably on access to such services by the elderly, who have the greatest need for aggressive monitoring and counseling in the use of medication.

SUMMARY

We have spoken today on the need for a reexamination of traditional thinking in the area of pharmaceutical services and prescription drug products, and their inclusion in federal government health services strategy. We believe the pharmacist can offer the elderly patient important and needed services that are clinically valid and cost-effective. We stand ready to work with you and your colleagues in this important area. Thank you for the opportunity to be with you today.

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The CHAIRMAN. Dr. Schlegel, you have testified that if patients take their prescription drugs when they are supposed to, you believe that it cuts down on the hospital costs of the elderly?

Dr. SCHLEGEL. Absolutely, sir. And one of the difficult problems is that many programs, including the Federal Government, have what I call "unbundled" these natural services that go to one another. So it makes it very difficult to determine the effect of one on the other. That's why this Pennsylvania study that I referred to is very, very important.

The CHAIRMAN. Yes, it's a truth that you and I have known and most members of this committee have known. Everyone on this committee understands.

Dr. SCHLEGEL. Absolutely.

If I may just interject, sir, the average cost of a prescription is in the $12 to $13 range, and all somebody has to do is decide not to take one because they have to pay the rent or they have to pay heating or whatever—it throws them into the hospital in an acute care situation. And how much does that cost per day? Several hundred dollars.

The CHAIRMAN. Right. Without prescription drugs, you might anticipate the eventual hospitalization cost would be about 10 times greater than the actual cost of the prescription. But that's sort of a rule of thumb; I don't know that everybody would subscribe to it, but I certainly subscribe to it. I think diabetes in particular—and a couple of the witnesses mentioned that may well be a good example. I can't envision how much it would cost for treatment if one-half of the elderly diabetics in the United States were not on medication. We would be looking at tremendous costs.

Dr. SCHLEGEL. Well, you heard a perfect example with Mrs. Morris this morning, who has decided not to take her beta blocker for her heart problem. And yes, a dollar per tablet seems very, very expensive, but the alternative from her not taking that is going to throw her into a crisis situation that, if it doesn't kill her, is going to put her into acute care in the hospital.

The CHAIRMAN. Yes. It's a very risky procedure that she's following, and yet I know that she's typical of millions of other elderly who skimp or avoid taking their prescribed drugs and take the risk.

Dr. SCHLEGEL. Correct.

The CHAIRMAN. Doctor, do you think that we're ready to do something, rather than continuously saying, as the Administration witness just testified, that a drug benefit costs too much and is too difficult to administer?

Dr. SCHLEGEL. Sir, I don't think we can afford not to do it. We cannot afford not to include the coverage of prescription drugs. Although some view the cost of prescription drugs as a cost center, in fact, there are reasonable data that show that ultimately, in the total system, they reduce costs.

The CHAIRMAN. Yes, and I think we ought to have a little wisdom and look beyond the nay-sayers in this case and just move on to what we know is right, correct and needed.

Thank you very much, Doctor.

Dr. SCHLEGEL. Thank you, sir.

The CHAIRMAN. Mr. Robert Allnutt, Executive Vice President, Pharmaceutical Manufacturers Association.

STATEMENT OF ROBERT ALLNUTT, EXECUTIVE VICE PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION

Mr. ALLNUTT. Thank you, Mr. Chairman. I will summarize the testimony very briefly. I thank you for bearing with me this long; it's been a long morning. What I'll do is just run very quickly through the statement and highlight some parts of it.

The first few pages cover the obvious fact that prescription medicines are helping people to live longer, healthier, and more productive lives. They're doing that for less than a nickel out of the national health care dollar for outpatient drugs. They are cost-effective, as many witnesses have said here this morning, in avoiding surgery, hospitalization, and other more costly forms of therapy.

It is through the sales of these products that the pharmaceutical industry raises the money that pays, among other things, for the research and development that is conducted, about $5 billion worth this year; and as you know, Mr. Chairman, that is roughly the same amount of money that the whole of NIH spends on all biomedical research in a year.

What we have been testifying for in recent weeks around the various fora here in Congress is in favor of a targeted Medicaid-type State-administered program to help people like those that you heard from this morning. I gather that is the kind of program that you are thinking of, some sort of targeted or means-tested program. Certainly, Senator Simpson also agreed with you this morning, as did—as I understood her testimony—Dr. Levens-Lipton and the AMA.

In addition, we have been saying that beyond a targeted program—for example, a program of Medicaid at 100 percent or 150 percent of the Federal poverty level—there should be in addition to that a study of the kind suggested by the Bentsen bill of what further needs there may be. That may not be all that's needed, and there should be a study to look beyond that. The kind of study we think should be conducted is outlined on pages 10 through 13 of my statement.

I believe beyond the obvious case of the poor who are in need of help with outpatient drugs, Mr. Chairman, there is inadequate knowledge at present of what further is needed. Page 7 responds to your letter asking us to testify by mentioning one additional study that we are aware of, a Johns Hopkins study a couple of years ago, that indicated about one percent of the elderly do not purchase drugs because of the cost. That's consistent with the two percent that is the figure that AARP comes up with in their study.

I also, on page 8, set forth a table that lists the various estimates that are being made as to the likely outcome of the bill that is moving through the House this week. And as you can see from that table, the estimates between the Congressional Budget Office and HCFA vary widely, as does experience under the various State Pharmaceutical Assistance to the Aged programs that are in place. There is wide divergence among those programs; that's the kind of

thing that needs to be understood before a general, universal entitlement program under Medicare is adopted, in our opinion.

On page 9 of the statement I have set forth what I characterized to the committee staff on Friday as a very preliminary attempt we've made to look at what the premiums would be that the elderly would pay under the House bill as it presently stands, as we understand it. That's a 150-page bill; it's kind of complex to look at. But for a family with an income of $28,500, we believe that in 1991 the premium for all of Medicare Part B would approach $2,500, and by 1995 would exceed $3,500. So we're talking, obviously, about the kinds of premiums that are most unlikely, ultimately, to be charged to people with an income of between $25,000 and $30,000 a year. But again, that's indicative of the kind of problem one could hit if general Medicare legislation is enacted at this time. That's why we urge targeting or means testing of the program.

Finally, the statement points out that Medicare legislation, unless other amendments are made to the law, would have the effect of making outpatient drugs for AIDS patients eligible for Medicare coverage. Clearly, the Federal and State governments are going to have to deal with the tragedy of AIDS, with the unbearable costs—not only in pharmaceutical products, but in other costs that AIDS patients are bearing. Whether that should be done under Medicare, I think, is a serious question that needs to be addressed.

That's a quick summary of the statement. I'd be glad to try to answer any questions you have.

[The prepared statement of Mr. Allnutt follows:]

Statement

Pharmaceutical Manufacturers Association

ROBERT F. ALLNUTT
EXECUTIVE VICE PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SPECIAL COMMITTEE ON AGING
U.S. SENATE

JULY 20, 1987

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before the Committee to testify on the important subject of prescription-drug coverage for elderly outpatients. PMA represents the more than 100 research-based pharmaceutical companies that discover, develop and produce most of the prescription medicines used in the United States.

Prescription medicines are a critically important component of the national health-care system. Our industry strongly believes that all older Americans should be able to receive the medicines they need, and we welcome the efforts of this Committee to focus on this issue.

The modern medicines our companies develop enable people to live longer, healthier and more productive lives. Drugs extend lives, cure illness and improve the quality of life for all Americans, especially the elderly. Indeed, senior citizens are among those who most use the medicines our companies discover and develop, and who benefit the most from these drugs.

Prescription drugs not only save lives--they save money. Prescription drugs are the most cost-effective form of modern therapy. They save billions of dollars a year by reducing the need for alternative, more expensive forms of therapy, such as

hospitalization and surgery. The use of drugs also reduces the cost of physicians' services and the number of work days lost due to illness. One anti-ulcer drug alone, Tagamet, saved Americans an estimated $4 billion in health-care costs in its first decade on the market.

Even though prescription drugs are the most cost-effective form of therapy, they represent only a small portion of health-care expenditures. As a nation, we spend less than a nickel of each health-care dollar for outpatient drugs. Drug prices have remained well below the Consumer Price Index ever since that Index was established in 1967 (Figure 1). And the cost of drugs has actually declined in terms of purchasing power.

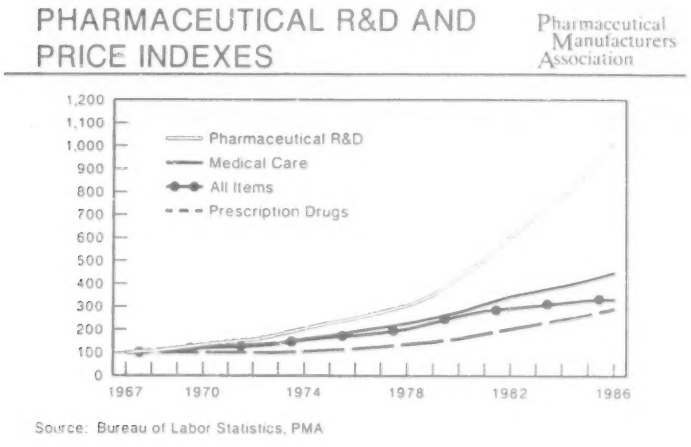


Figure 1

Every five years since 1970, the pharmaceutical industry has doubled its investment in research and development (Figure 2). This year, our companies are investing $5 billion in R&D, nearly equalling the total being spent by the National Institutes of Health for all biomedical research. The period of time during which this investment in R&D can be recovered through sales revenues, however, is being dramatically compressed due to a number of converging forces. Foremost among these forces is the unprecedented surge in competition from generic products as soon as the patent on a pioneer drug expires. Other major forces

include the intense competition within the research-based pharmaceutical industry to develop and market new patented drugs; increasing delays in the approval of new drugs, and increasing foreign competition both from developed countries that have targeted this industry and from newly industrialized countries that blatantly condone patent piracy.

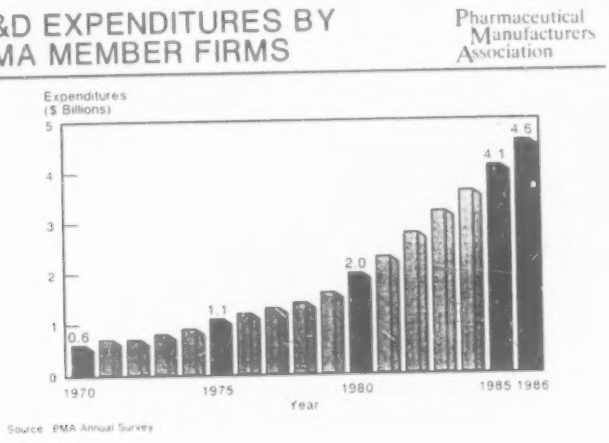


Figure 2

It is because prescription drugs are necessary to ensure that all people receive the very best health care and because they are the most cost-effective form of health care that the industry believes older Americans should have access to the full range of prescription drugs. In recent weeks, I have testified before the Health Subcommittees of the Senate Finance Committee, the House Ways and Means Committee and the House Energy and Commerce Committee. The main thrust of that testimony was to urge Congress to take the time to carefully craft a plan to reimburse needy elderly persons for their drugs, through an appropriate mix of federal, state and private programs.

The danger we see in hasty adoption of a new universal entitlement program--without carefully defining the problem so an appropriate solution can be devised--is that the costs of the

program, and of its administration, will quickly exceed the initial estimates. This will lead inevitably to ever higher premiums and budget deficits, and to proposals for cost-containment measures. These measures typically would restrict freedom of choice from the full range of approved drug products, diminish quality of care and discourage the investment needed for future drug breakthroughs. Those in need thus would be denied the very benefits intended for them, resulting in second-class care for the beneficiaries of federal programs. Indeed, several such undesirable cost-containment features have already appeared in various bills.

In a few days, the House will consider a bill (H.R. 2941) to extend Medicare to cover prescription drugs for elderly outpatients. Adding this benefit to Medicare would, of course, reimburse all elderly and disabled persons for their prescription-drug costs (above the deductible and co-insurance amounts specified in the bill), regardless of their ability to pay.

The vast majority of Americans, including elderly people, are financially able to obtain drug therapy. At this time, however, there are no reliable data defining the number of elderly people who cannot obtain adequate drug therapy for financial reasons. It is absolutely essential to determine the size and characteristics of such a group of older persons before it can be determined how to design an appropriate--and affordable--program.

One of the specific questions you asked us, Mr. Chairman, was about the impact of the cost of drugs on the use of drugs by elderly persons. We know of no definitive study of this issue that would allow a program to be carefully designed to provide drugs for those elderly people who do not have the resources to obtain them. This is one of the main reasons we have urged that a comprehensive study be undertaken before a drug-benefit program is enacted. Two recent reports do suggest, however, that cost has a limited impact on drug use by the elderly.

In a March 1987 Issue Brief, the American Association of Retired Persons cited a survey (of persons 45 years of age and

older) in which 2 percent of the respondents said they had decided not to fill a prescription within the last two years because of the cost of a drug. This result is consistent with a more relevant study by the Center for Health Services Research at Johns Hopkins University, funded by the National Institute on Aging in 1985, of 740 low-income, elderly patients at the Francis Scott Key Hospital in Baltimore. This study (Drug Side Effects and Functional Capacity in the Elderly) found that about 1 percent of the group discontinued the use of a drug because of cost. The main reasons given for not continuing to use a drug were improved health, confusion about directions and side effects.

Even the strongest proponents of expansive new drug coverage acknowledge that little data exist on the potential use of a new drug benefit under Medicare, the costs of such coverage and the administration of such a program.

The Congressional Budget Office and the Health Care Financing Administration have been hurriedly preparing estimates of the cost of covering prescription drugs under Medicare over the past few weeks. These estimates differ by a considerable margin, as the following table shows:

Medicare Drug Coverage for the Elderly
Variations in Key Cost Elements

	Expenditures Per Enrollee (1986 Unless Noted)	% of Enrollees Spending More Than $500
CBO	$250 *	17%
HCFA	$342 *	25%
Blue Cross/ Blue Shield Group Plans		
-Michigan	$312 **	?
-Illinois	$388 **	?
-New York	$380 **	27%
Medicaid (1985)	$368 **	?
New Jersey Pharm. Asst. Program	$380 **	?
Pennsylvania PACE Program	$473 **	21%

* Estimated (1988)
** Based on Actual Data

Clearly, a new drug benefit under Medicare should not be enacted until reliable estimates can be made of how much such a benefit would cost, and what premiums or taxes would be required to pay for the new program.

In considering these matters, we believe the Senate should also keep in mind the overall result of the amendments being proposed to Medicare Part B. Based on a draft of the House bill available to us last week, it appears the premiums for Part B would reach extremely high levels in a few years. For example, according to our preliminary estimates, the premium for catastrophic coverage for a family of two with a current annual income of $28,500 would be $1,650 a year in 1991. That family's premium for drug coverage would be $227 a year. Their total annual premium for Medicare Part B would be $2,484, compared to $429 today.

By 1995, according to our estimates, the total premium (again, for a family of two with a current annual income of $28,500) would rise to $3,718 a year, including $2,554 for catastrophic coverage, $470 for drug coverage and $693 for current coverage. That is an eight-fold increase over today's level, and calls into serious question the realism of the benefits and premiums being considered.

In light of these potential costs, PMA believes it is essential to identify the group in need of a drug benefit so a limited, affordable program can be designed. A well-designed program should have several important features. It should:

- Be targeted to aid the elderly who need assistance, so the added premiums or taxes required to cover costs can be minimized.

- Assure that patients receive quality care.

- Provide physicians and patients with the freedom to choose from the full range of approved drug products.

- Include a low-cost, non-burdensome administrative procedure.

- Encourage--and not stifle--the continued development of new and more effective medicines.

Before Congress provides any new entitlement program, PMA urges that a comprehensive study be undertaken. A study is required to develop and analyze the data necessary to determine the most appropriate way for the government to provide prescription-drug coverage for the elderly in an affordable manner.

We note that S. 1127 as reported by the Finance Committee contains a requirement to study drug benefits, and we urge that the study include these additional factors:

- Determination of current levels of spending by the elderly for prescription drugs, as well as the number of older persons unable to afford adequate drug therapy, should be the top priority.

- The long-term fiscal integrity of Medicare should be preserved. As discussed above, the danger of driving the elderly to adverse selection of Part B should not be overlooked.

- There are other pressing medical needs as well, including the billions of dollars in previously unplanned expenditures that we now know inevitably will be required in federal and state budgets to meet AIDS-related demands in the early 1990s. None of the estimates of providing a new program of drug coverage under Medicare take into account the substantial cost of medicines for AIDS victims that would be paid under the House bill.

- Nine states (New York, Pennsylvania, Illinois, Maine, Rhode Island, Connecticut, New Jersey, Delaware and Maryland) already have enacted Pharmaceutical Assistance for the Aged programs for low-income elderly persons who do not qualify for Medicaid benefits. These programs cover 1.3 million people. Six additional states (Massachusetts, Ohio,

Michigan, Vermont, Florida and Alabama) are considering such programs. These efforts should be carefully studied, and consideration should be given as to how a federal assistance program should relate to existing state-administered Medicaid drug programs--under which 2 1/2 million elderly Americans received drug benefits in Fiscal Year 1985--and Pharmaceutical Assistance for the Aged systems.

- The manner in which a federal program would interrelate with other forms of drug coverage should also be considered. Many elderly people are covered by private insurance, Veterans programs, private retirement plans and Health Maintenance Organizations (HMOs). The AARP has testified that more than 41 percent of the elderly population has some form of drug coverage. More than 50 percent of the enrollees in the Pennsylvania assistance program have other coverage.

- Special attention should be given to administrative procedures, in view of the fact that, because of the large number of transactions, administrative costs tend to be very high for drug programs. Secretary of Health and Human Services Otis R. Bowen, in testifying before the House Energy and Commerce Subcommittee on Health and the Environment on May 27, said the administrative costs of a new drug program under Medicare would greatly exceed $500 million. HCFA estimates this cost at $510 million by 1992. In a 1986 report, the House Appropriations Committee pointed out that less than 8 percent of Medicaid benefits are for drugs--but that these benefits account for 50 percent of the paperwork. And the United Auto Workers noted in recent testimony that it would be very costly to administer a program of drug benefits with a high deductible.

- The incentives for continued investment in pharmaceutical research and development should be preserved, and not impaired. The best hope to treat disease--including diseases of special concern to the elderly such as heart disease, cancer and Alzheimer's disease--lies in the R&D efforts of the research-based pharmaceutical industry.

Finally, Mr. Chairman, the legislation being considered by the House contains a cumbersome generic-prescribing scheme that would sweep aside the laws of all 50 states and establish different rules for Medicare patients. Under this scheme, elderly Medicare patients would be given a generic drug, unless the prescribing physician specified otherwise in quite precise language. This would make it very difficult for physicians to ensure that their elderly Medicare patients receive the medicine they intend to prescribe, and could be espeoially risky for those patients with serious chronic conditions stabilized on a particular product. We maintain that existing state prescribing laws should apply to elderly Medicare patients as well as to all other patients.

In conclusion, PMA strongly believes that older Americans should receive the very best and most cost-effective medical care, including the full range of modern medicines. At this time, however, there are far more questions than answers about the best way to design a new drug-benefit program in support of this goal. Congress should authorize a comprehensive study, on an expedited basis, to develop the data necessary to design an appropriate and affordable program. PMA will continue its own review of the options, and would be pleased to cooperate fully with a Congressional study.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you or other members of the Committee may have.

The CHAIRMAN. Well, I'm trying to digest both your statement and your comments. By the way, all of your statement will be made a part of the record. But after scanning through your statement and then listening to your comments, I'm a little bit confused.

Mr. ALLNUTT. That's my fault and not yours, sir, if I've confused you.

The CHAIRMAN. Well, I think your last statement was to the effect that you approve of some sort of means testing. Does that mean that you advocate some type of broadening of Medicare or not?

Mr. ALLNUTT. Whether it's Medicare or done strictly under the Medicaid program. We have supported over in the House in recent weeks the proposal that has been made to simply mandate to the States coverage of outpatient drugs through Medicaid up to 100 or 150 percent of the Federal poverty level. As you know, Mr. Chairman, many States have set their Medicaid reimbursement levels for drugs well below the Federal poverty level. This would mandate that it goes to 100 percent or 150 percent. We think that kind of program makes sense.

The CHAIRMAN. Well, this is what bothers me, and it's been mentioned several times, "well, tie it to Medicaid." None of the three people we heard from are on Medicaid.

Mr. ALLNUTT. I believe you'll find—and I'm not an expert on the State-by-State limitations on Medicaid—but I think if you had a Federal requirement that States cover outpatient drugs for people up to 100 percent of the Federal poverty level, or 150 percent, which has been proposed in the House, I suspect that all three of these people would have been covered.

The CHAIRMAN. I don't believe so. First of all, we're talking about women who are single; and secondly, we're talking about people who really don't want to be associated with being labeled "welfare recipients." And so, while I am very much convinced that we're going to have to have some sort of means testing, I'm not certain that when we say "Medicaid" that we're getting to the problem at all.

Mr. ALLNUTT. If the term, "Medicaid," has a stigma and people would not want to be covered that way, then I would presume that a clever draftsman could reach the same result under Medicare with means testing. The end result should be the same. Obviously, no one can listen to the kinds of stories that we heard this morning and not be touched by them, not feel that there needs to be some form of assistance, Federal, State, local or otherwise, for such people. It's a question of what forum is right to use to do that.

The CHAIRMAN. All right. Thank you very much, Mr. Allnutt, for your testimony.

Mr. ALLNUTT. Thank you.

The CHAIRMAN. That concludes our hearing this morning. The hearing record will be held open for two weeks for anyone who desires to augment the testimony received today, just simply by

giving to the committee written testimony in any form they care to make it. We'll make that part of the hearing record.

Thank you all very much. The committee is adjourned.

[Whereupon, at 12:37 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

GAO

United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and
Methodology Division

July, 1987

MEDICARE

Prescription Drug Issues

The Honorable John Melcher
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

On July 14, 1987, you asked us for information about prescription drugs as they relate to the needs of the elderly. In particular, you were interested in the following questions:

1. To what extent do the elderly need and use prescription drugs and what are the costs to the elderly?

2. What prescription drug benefits, other than inpatient benefits, are covered under Medicare?

3. To what extent does Medicaid provide prescription drug benefits?

4. What states have separate programs to provide assistance to the elderly for prescription drugs? What kind of assistance do these programs provide and who benefits from them?

5. What provisions are included in H.R. 2470 and S. 1127 that pertain to prescription drug benefits and to what extent will these benefits meet the needs of the elderly?

SCOPE AND METHODOLOGY

The information in this letter responds to these questions and is based, in part, upon the results of the ongoing study of catastrophic illness insurance that we are also performing at your request. Matters pertaining to prescription drugs will be only one small part of the larger study, on which we expect to issue a report to you at a later time.

Our information is for the most part derived from documents that we have reviewed, but which we have not independently verified, and from two legislative proposals to expand Medicare coverage for catastrophic illness: the House Ways and Means Committee bill H.R. 2470 as amended by the House Committee on Energy and Commerce and the Senate Finance Committee bill S. 1127, both entitled "The Medicare Catastrophic Loss Prevention Act of 1987."

We begin with demographic information about use and cost and then briefly discuss prescription drug coverage under Medicare, under Medicaid, and in states that have developed programs specifically to meet this need. We close with a discussion of how H.R. 2470 and S. 1127 would provide benefits for prescription drugs for the elderly and the groups of the population that would remain without benefits if these bills were enacted.

USE AND COST

That the cost of prescription drugs is rapidly rising is an important fact for the millions of the elderly suffering from diabetes, high blood pressure, various heart conditions, some types of cancer, and other conditions. They depend on medication to help control these problems, so that buying prescription drugs is a major out-of-pocket health care expense for them.

More than 75 percent of the persons older than 65 in this country use prescription drugs; for the elderly who are chronically ill, this figure is 90 percent.

Persons 65 and older use 30 percent of all the prescription drugs used in the United States--approximately three times the rate of the population younger than 65.

For three of every four elderly persons, prescription drugs are the largest out-of-pocket health-care expense. A 1986 study commissioned by the American Association of Retired Persons (AARP) estimated that drug expenditures for persons 65 years old and older are $9 billion annually and that $7.3 billion of this is out-of-pocket expense.

From January 1980 through 1986, the cost of prescription drugs rose about 80 percent--two and a half times faster than the rise in consumer prices in general.

According to a report by the Public Health Service, 15.5 percent of the elderly patients who require prescriptions said they are unable to pay for their drugs. An AARP survey reported the cost of prescription drugs as an important reason why the elderly often do not get their prescriptions filled.

MEDICARE COVERAGE

Under current law, Medicare generally covers inpatient drugs but pays for outpatient drugs in only a few instances.

Outpatient prescription drugs are generally not covered by Medicare Part B, with the exception of drugs that require injection by a physician or nurse. Injections that patients commonly administer to themselves, like insulin, are in general not covered. (Self-administered drugs that must be administered by a physician or nurse in an emergency are covered, and so are blood-clotting factors for certain hemophilia patients.) Pills and other oral medications are excluded from Part B because they are self-administered.

Medicare does pay for outpatient use of immunosuppressant drugs (such as cycloserine) in the first year following a Medicare-covered transplant operation.

The Congressional Budget Office (CBO) estimates that the costs of providing immunosuppressant drugs to 9,000 Medicare beneficiaries with organ transplants will approach $35 million in 1987, or about $4,000 per beneficiary.

Immunizations are covered only in specific circumstances: vaccination against pneumococcal pneumonia, and hepatitis B (for those at medium or high risk only), and immunization directly related to the treatment of an injury or direct exposure to a disease or condition such as rabies or tetanus. Most immunizations, such as for smallpox and influenza, are not covered.

Medicare beneficiaries may enroll in health maintenance organizations (HMO's) and competitive medical plans that cover all Part A and Part B benefits and that may include prescription drugs. In most cases, the beneficiaries pay an additional premium for drugs and other benefits directly to the HMO or plan. In May 1987, the records showed 914,715 Medicare beneficiaries enrolled under "risk contracts" with 152 HMO's or plans. Outpatient drug benefits were offered by 115, or 76 percent, of the contractors.

MEDICAID COVERAGE

Medicaid provides optional prescription drug coverage for the low-income elderly in most states. As shown in appendix I, all the states except Alaska and Wyoming reportedly provide some coverage. As indicated in the appendix, 10 states impose major restrictions on drug coverage.

According to the Health Care Financing Administration (HCFA), 2.2 million Medicare enrollees are covered by state Medicaid programs.

Also, according to HCFA, the 2.4 million recipients of drug benefits under Medicaid in fiscal year 1986 accounted for $972.6 million in expenditures.

Medicaid pays the lower of the cost of the ingredients of prescribed drugs plus a reasonable dispensing fee or a provider's usual and customary charge to the general public.

Some states may limit the benefits they will pay, requiring the recipient to pay any costs above an estimated acquisition cost--a state Medicaid agency's best estimate of the price that providers are generally paying for a prescribed drug.

Medicaid limits benefits for the cost of drugs--including generic drugs--marketed by two or more drug companies to the lower of the maximum allowable cost established by HCFA's pharmaceutical reimbursement board (and published in the Federal Register) or the estimated acquisition costs. A state may also establish its own list of maximum allowable costs. (The cost of a multiple-source drug is not limited by this list if the physician certifies in handwriting that, in his or her professional judgment, a specific brand is medically necessary for the patient.)

Of the 48 states with a prescription drug program under Medicaid, 22 charge recipient copayments which range from $0.50 to $3.00.

State Medicaid agencies may place additional limits on benefits for prescription drugs, such as limits on the number of prescriptions that can be filled in a certain time period or limits on the quantity of each prescription that may be filled at one time.

COVERAGE UNDER STATE PROGRAMS

Nine states offer specific programs covering some drug benefits for portions of their populace: Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey, New York, Pennsylvania, and Rhode Island. (See appendix II for the basic structure of these programs.) This means that 41 other states do not have such programs; even in the 9 states with programs some portions of the population do not receive assistance in purchasing drugs because of eligibility requirements or copayments.

All 9 programs have an income level above which people are ineligible, and 8 have some copayment provisions. Some states set their income thresholds higher than others, thus allowing more people to participate. For example, New Jersey's level is $16,750 for couples, Connecticut's is $16,000, and Pennsylvania's is $15,000. Other states, such as Delaware, Maine, and Maryland, set their income eligibility relatively low, increasing the chance that the nearly-poor will not receive benefits. Some states set copayment levels relatively low--$1 or $2 per prescription--and one program has an upper limit. Other states, such as New York and Rhode Island, set higher copayment levels (New York's sliding scale approximates a 40-percent copayment) in order to keep the costs of the program down and to create incentives for the recipients to seek the lowest drug prices and to use generic drugs.

Individuals receiving benefits as a percentage of the elderly population in a state range from 4 percent to 27 percent. This leaves a sizable number of elderly who do not benefit--as many as 96 percent in Illinois. Lack of participation may be because people need prescription drugs but do not meet the eligibility requirements or because they do not need the drugs covered by the programs. We do not know the proportions of the elderly that fall into either category.

Some of these programs have features that can be instructive for a federal program. For example, New Jersey, the first state to establish a program, has experienced considerable cost growth. The cost was $35 million in 1978, $70 million in 1984, and $96 million in 1986. An initially large cost doubled in 6 years and almost tripled in 8 years. In order to deal with this cost growth, New Jersey increased its copayment from $1 to $2, included a provision for prescribing generic drugs, set a maximum-allowable-cost provision, and tightened the residency requirements. The lesson is that precautions should be taken from the start.

In Maryland, eligibility is based on income and assets, not on age. Currently, 62 percent of the recipients are older than 64, 26 percent are between 64 and 45, and 12 percent are younger than 45. In other words, in a program that does not base eligibility restrictions on age, a sizable proportion of nonelderly individuals who have pharmaceutical needs will take advantage of benefits, if they are offered.

In Pennsylvania, copayments can go up or down, depending upon the actual costs of the drugs. Pennsylvania is concerned with rapid cost increases. In the first year, it paid out $62 million; in the second year, it paid out twice and in the third year three times that amount. To control its cost increases, the Pennsylvania program developed three forms of cost control: (1) it developed a review of the program's use, (2) it targeted various education projects to consumers, physicians, and health and social services practitioners, and (3) it expanded its efforts to recover money from insurance companies (since the state is a "payer of last resort"). It is clear that cost control must be addressed.

Rhode Island designed its program intentionally to be what its director calls "conservative." Having examined the experience of some other states, particularly Pennsylvania, Rhode Island saw the need to create a small program that could function within limited budget constraints.

COVERAGE UNDER H.R. 2470 AND S. 1127

On June 17, 1987, the House Committee on Energy and Commerce reported out an amended version of H.R. 2470 that would cover the cost of prescription drugs for Medicare beneficiaries. We discuss its scope below, as well as that of S. 1127.

The amended H.R. 2470 would expand Part B to include 80 percent of all reasonable costs for self-administered prescription drugs, insulin, and approved "biologicals" over a deductible amount. The deductible would be $500 for

calendar year 1989 and indexed to the medical component of the consumer price index. The deductible and other expenses that enrollees incur for drugs would not count toward the bill's proposed limit of $1,042 for drugs for catastrophic illness.

Medicare beneficiaries are liable for 20 percent coinsurance for each prescription after the deductible has been met.

It is estimated that for the elderly, the 1988 annual per capita expenditure on prescription drugs would be $250 in 1988, $268 in 1989, and $331 in 1992. Further, it is estimated that 5.5 million, or 16.9 percent, of the Medicare Part B enrollees would exceed the $500 deductible on prescription drugs in 1989, at an estimated cost of $965 million.

CBO also indicates that the use of prescription drugs would rise only slightly under this proposal because of the large deductible and the fact that drug use is determined by physicians.

The new benefit would be financed entirely with a monthly premium that would be paid by all enrollees under Part B of Medicare, and the amount of this premium they would pay for drugs would increase $0.30 in 1988, $3.60 in 1989, $5.60 in 1990, $6.30 in 1991, and $6.80 in 1992. However, the bill would require the states, through their Medicaid programs, to cover both the Medicare Part B premium (including any increment attributable to the prescription drug benefit) and the $500 deductible for all elderly and disabled Medicare beneficiaries whose incomes are below the federal poverty line and whose countable resources are no more than twice the level permitted by the Supplementary Security Income program ($3,600 in 1987).

The amended version of S. 1127 focuses directly on only immunosuppressive drugs for organ transplants. Broader coverage is to be determined at a later date. The relevant provisions would count the cost of immunosuppressive drug therapy toward the Medicare Part B copayment cap. Medicare now covers 80 percent of the cost of the first year of this therapy after an approved organ transplant operation, but patients must pay all costs thereafter.

The Senate bill also calls for a study by the Institute of Medicine to examine prescription drug use, costs, and coverage policy.

In summary, the addition of coverage for prescription drugs for Medicare enrollees under H.R. 2470 and S. 1127 would reduce their out-of-pocket expenditures. The reduction would be greater under H.R. 2470. However, the proposed deductible of $500 might limit the participation of the nearly-poor, limiting the extent this provision would help them, particularly the elderly who do not have supplementary insurance under private coverage. The provision in H.R. 2470 that requires the states to cover through Medicaid the program costs for the elderly below the federal poverty level would provide protection for the poor.

FINAL COMMENT

We have reviewed the issue of prescription drugs from the perspectives of use and costs, and we have looked at proposed assistance to the elderly as they pay for their prescription drugs. We note the tension between an identified need and the question of how to control costs. Many of the elderly need drugs and cannot afford them. However, we see that when state programs provide these benefits, costs are sometimes sizable and fast-growing. The substantial deductions and copayments in H.R. 2470 and S. 1127 are intended to address this issue. We hope that the facts that we have provided will be useful to you.

VIEWS OF AGENCY OFFICIALS

Because of the time, we did not obtain official agency comments on this letter. Unless you plan to publicly announce its contents earlier, we do not plan to distribute it for 30 days.

If you have any questions, please call me at (202) 275-3092 or James Solomon at (202) 275-0200.

Sincerely,

Carl Wisler

Carl Wisler
Acting Director

APPENDIX I

APPENDIX I

STATE MEDICAID COVERAGE

State	Copayment	Formulary	Restrictions: Excludes drugs	Restricts drugs to specific illness	Restrictions: Other major restrictions
Alabama	$0.50-$3.00	yes		yes	
Alaska	No drug program	a			
Arizona	b	a			
Arkansas	0	no	yes		6 Rx/month
California	$1.00 (optional)	yes		yes	
Colorado	$0.50	no	yes		
Connecticut	0	no	yes		
Delaware	0	no	yes		
District of Columbia	$0.50	no	yes		
Florida	0	no	yes		$22/month
Georgia	0	yes		yes	6 Rx/month
Hawaii	0	yes		yes	
Idaho	0	no	yes		
Illinois	0	yes		yes	
Indiana	0	no	yes		
Iowa	$1.00	no	yes		
Kansas	$1.00	yes		yes	
Kentucky	0	yes		yes	
Louisiana	0	no	yes		
Maine	$0.50	no	yes		
Maryland	$0.50 (for state funded)	no	yes		
Massachusetts	0	no	yes		
Michigan	$0.50	yes		yes	
Minnesota	0	yes		yes	
Mississippi	$1.00	yes		yes	6 Rx/month
Missouri	$0.50-$2.00	yes		yes	5 Rx/month
Montana	$0.50	no			
Nebraska	0	no	yes		
Nevada	$1.00	no	yes		3 Rx/month
New Hampshire	$0.75	no	yes		
New Jersey	0	no	yes		
New Mexico	0	no	yes		
New York	0	yes		yes	
North Carolina	$0.50	no			6 Rx/month
North Dakota	0	no			
Ohio	0	yes		yes	
Oklahoma	0	yes		yes	3 Rx/month
Oregon	0	no	yes		
Pennsylvania	$0.50	no	yes		
Rhode Island	0	yes		yes	
South Carolina	$0.50	no	yes		3 Rx/month
South Dakota	$1.00	yes		yes	
Tennessee	0	yes		yes	7 Rx/month
Texas	0	no			
Utah	0	no	yes		
Vermont	$1.00	no	yes		
Virginia	$0.50-$1.00	no	yes		
Washington	0	yes		yes	
West Virginia	$0.50-$1.00	yes		yes	
Wisconsin	$0.50	no	yes		
Wyoming	No drug program	a			

[a] Not applicable.

[b] There is no copayment, depending on a formula under an Arizona Health Care Cost Containment System capitation plan.

Source: Joseph A. Cialowski, "Coverage of Outpatient Prescription Drugs," report for the Senate Finance Committee, Congressional Research Service, Washington, D.C., June 15, 1987.

APPENDIX II

STATE PRESCRIPTION DRUG PROGRAMS

				Program characteristics							
State	Year enacted	Age	Maximum income	Copayment	Drugs covered	Funding	Annual cost (million)	Number of recipients	Total population 65 +	Recipients as % of population 65 +
Maine	1977	62+	$ 6,630 single, $ 7,950 couple	$2.00	Most Rx for heart, blood pressure, diabetes, and antiarthritic drugs	General fund	$ 1.6	25,000	152,000	16%
New Jersey	1977	65+	$11,650 single, $16,750 couple	$2.00	All Rx, insulin, and test materials	About 2/3 general funds and 1/3 casino funds	$ 96.1	199,299	942,000	21%
Maryland	1979	None	$ 6,100 single- $11,950 family of 10	$1.00	All Rx and Medicaid over-the-counter	General fund	$ 1.3	15,000[a]	441,000	b
Delaware[c]	1982	65+	$ 7,500 single, $10,600 couple	15% of cost	All Rx and insulin	Dupont de Nemours Foundation	$ 1.1	10,000[d]	67,000	15%
Pennsylvania	1984	65+	$12,000 single, $15,000 couple	$4.00	All Rx for 30-day supply or 100 doses	Lottery	$100.0	466,432	1,466,000	27%
Illinois	1981	65+	$14,000 household	e	Cardiovascular, diabetes, and antiarthritic drugs	General fund	About $ 13.6	56,176	1,120,000	4%
Rhode Island	1981	65+	$ 9,000 single, $12,000 couple	40% of cost	Rx for specific categories of disease	General fund	$ 2.1[f]	12,100	130,000	9%
Connecticut	1986	65+	$13,100 single, $16,000 couple	$4.00	All Rx	General fund	$ 15.0	31,852	407,000	8%
New York	1986	65+	$ 9,000 single, $12,000 couple, low income; $15,000 single, $20,000 couple, medium income	g	All Rx	General fund	Projected $150.0	470,000[h]	2,234,000	21%

[a] Average monthly enrollment in fiscal year 1987.
[b] Percentage not calculated since the program serves all age groups and not just the elderly.
[c] Not a vendor drug program; all prescriptions are dispensed through the Nemours Memorial Health Clinic, Wilmington, Delaware.
[d] About 6,500 people are active in the program at any one time; 10,000 were enrolled in 1987.
[e] No copayment but an $80 annual fee.
[f] Total costs for the first 21 months of the program, including administrative costs.
[g] About 40 percent of cost plus a quarterly registration fee or an annual premium related to income.
[h] An estimated 1.2 million are eligible.

Item 2

Executive Director
William R. Hutton
Washington, DC

National Council of Senior Citizens

President
Jacob Clayman
Silver Spring, MD

925 Fifteenth Street, N.W. • Washington, D.C. 20005 • (202) 347-8800

Testimony Before The

Senate Special Committee on Aging

by

Jacob Clayman
President

National Council of Senior Citizens

Mr. Chairman:

Thank you very much for holding this hearing to take a closer look at one of the most important issues in the catastrophic debate: coverage of prescription drugs. Thank you also for giving us the opportunity to testify this morning. The National Council of Senior Citizens has worked tirelessly for many years on this specific issue and we are very grateful for the sincere interest in prescription drug coverage that you and the Members of your Committee have shown.

Without a doubt, the list of changes, improvements, and additions that should and could be made to our Federal health programs is nearly limitless. But our ability to make these changes is severely limited by our ability to finance them. So we are forced to choose only a few from a long list of meritorious ideas. When we talk to our members and ask them what the most important changes or improvements are that could be made--when we ask them what they really want--I suspect the answers we get are very similar to what your constituents tell you. Almost without fail, the most important items to seniors themselves are long-term care and prescription drug coverage under Medicare.

Some of our members place a higher priority on long-term care, others on prescription drugs. As an example, I offer you the words of an NCSC member who wrote us just last week:

> "...sure do hope that you will be able to convince our government to add prescription drugs on Medicare; more so than nursing homes, as everyone likes to stay at home. We wouldn't even mind paying something extra for the prescription addition to Medicare, as drugs are really getting so high in cost...."
>
> Victor Mance
> Madison, Illinois

I. NEED

For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket expense they will face. Many elderly individuals take four to five drugs a day and, on average, fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. It's also important to realize that the over-65 population is prescribed drugs three times more often than the under-65 population. The elderly in one year take, on average, 10.5 prescription drugs compared to 4.2 prescriptions for the rest of the population. Many seniors with the chronic and debilitating diseases of arthritis, diabetes, cancer, and cardiovascular disease must take prescription drugs every day of their lives for a period of many years.

II. COST

The costs seniors face for prescription drugs are enormous. The elderly's drug bill amounts to over $9 billion annually--more than twice that of the rest of the population. Payments for drugs represent 20 percent of the elderly's total out-of-pocket health care costs.

Unfortunately, unlike most other health care costs, there are extremely few sources of coverage for the costs of prescription drugs. Neither Medigap nor Medicare will pay for the cost of these drugs outside of a hospital. In fact, a recent statement released by Aetna on this subject said, "Medicare doesn't cover many items, such as drugs....Neither do most Medicare supplement policies, which are generally based on what Medicare does cover." Even Medicaid only covers the costs of prescription drugs for one-third of the poor, leaving without protection 6.2 million near-poor seniors whose incomes are less than twice the Federal poverty line. This means that 80 percent of the elderly have to pay these costs out of their own pockets--amounting to over $7 billion annually.

For many seniors, prescription drug costs are catastrophic in the truest sense. As witnesses for the Department of Health and Human Services stated in a hearing held in March, more than two-thirds of the elderly population has out-of-pocket expenses due to prescription drugs each year. 6.3 percent of the elderly accounted for 55 percent of total out-of-pocket expenditures, and one percent

of the elderly accounted for 15 percent of total out-of-pocket expenditures. Clearly, the burden falls very heavily on a few, and for most seniors, no coverage alternatives exist.

The costs of prescription drugs can be prohibitive for these seniors. According to one Public Health Report, 15.5 percent of elderly patients with prescriptions said they were unable to pay for the drugs. Many of these patients find themselves "too wealthy" to be on Medicaid, but too poor to be able to meet these costs themselves. For many of these seniors, being handed a prescription amounts to being handed a choice: pay the rent, buy groceries, or fill the prescription. Not surprisingly, seniors in this situation often choose to do without the drugs they need for no reason other than they can't afford them--a truly disgraceful situation and one that should not exist in our health care system.

Neither is the situation a good one even from the straight dollars and cents point of view. Outlays for drug costs can be more than offset by savings. After the State of New Jersey implemented its Pharmaceutical Assistance to the Aged (PAA) program, Medicare recipients had, on average, $238.50 less in inpatient hospital reimbursement costs than a comparable group had in Pennsylvania where no program was offered. (Unpublished study, Department of Pharmacy Practice, University of South Carolina,)

Juxtapose high costs with the extraordinarily high rate of inflation and high rates of profit in the prescription drug industry and it's easy to see a big part of the reason for the increased financial burden borne by the elderly. Since July 1985, while the CPI has risen 2.7 percent, retail prescription drug prices have risen 12.2 percent--a record four and one-half times greater. Last year, prices for prescription drugs outpaced all other medical costs. Tranquilizers and sedatives, which are often prescribed for older people, posted the biggest price increase of 13.2 percent. Between 1981 and 1985, while the CPI rose 23 percent, drug prices rose 56 percent. Costs of medications vital to the elderly in treating heart problems, high blood pressure, and arthritis have risen twice the rate of annual inflation since 1980.

At the same time, pharmaceutical corporations enjoyed profits of 13.2 cents on the dollar, compared to 4.6 cents for all manufacturers, and profits in this industry have traditionally outpaced the average profit for all other industries by two and even three times.

III. FINANCING

The ability to finance and put in place a long-term care benefit may be beyond the current debate, but the ability to finance and put in place a prescription drug benefit under Medicare is clearly within our reach. In my opinion, the addition of a modest prescription drug benefit to the catastrophic package we have before us would greatly enhance the usefulness and attractiveness of the whole package.

We believe that the best, fairest and most logical way to pay for prescription drug benefit is to require state and local employees to pay the HI (Hospital Insurance) payroll tax. This would raise about what is necessary to finance a drug benefit with a $300 deductible and a $2.00 to $3.00 co-pay. It is simply unfair to continue to allow one group of workers to receive privileged treatment in terms of paying for and receiving the benefits of Medicare protection.

I think those who would say this should be done but for the purpose of deficit reduction, are being greedy. Let's not forget that out-of-pocket costs for the elderly have risen 34 percent, between 1980 and 1985, as a direct result of high health care inflation and Medicare beneficiary cuts. We believe it's time to give some of that back.

However, if the Congress chooses not to use state and local coverage as a financing mechanism, we would urge that alternative financing be found. Although we would be extremely reluctant to increase the Part B premium any further, as you have heard, our members would be willing to pay for a prescription drug benefit if it would help relieve this terrible burden.

IV. COVERAGE OPTIONS

The National Council of Senior Citizens strongly urges the Congress to include a prescription drug benefit in the catastrophic health care package. This coverage is badly needed and is not available from almost any other source. At the same time, it would give the catastrophic package broad appeal and give this nation's seniors a real source of protection from the high cost of drugs.

We suggest that a Medicare drug benefit should include some combination of deductibles and co-payments, and should include cost controls.

Deductible

Ideally, a deductible should be set at a point where it would be low enough to enable needy seniors to benefit from the

provision, but high enough to help keep costs down. Of course, as the deductible moves higher, fewer people are helped and those who are helped are helped for shorter amounts of time. As has been pointed out in this regard, a high deductible might be reached only in the last month of a year, meaning that coverage would kick in only one month out of 12--hardly worth the administrative effort.

Co-pay

At the same time, NCSC would hope that any co-pay would be set at a point low enough so as not to be prohibitive for lower income seniors. A co-pay could be structured either in the way of a straight dollar amount per prescription filled or as a percentage of the cost of the prescription. However, we would point out that a percentage co-pay avoids the problem of paying the same amount for a prescription whether it is for 100 pills or ten.

Other Cost Controls

One of the most important concepts to keep in mind in discussing a prescription drug benefit is the inherent ability it gives the Federal government to control escalating drug costs. Just as PPS helped reduce the problem of double-digit inflation in hospital care, so too could inclusion of drugs under Medicare help solve the problem of inflation in that part of the health care industry. The Federal government, as a major purchaser of control mechanisms that would likely be followed by private prescription drugs, would have the ability to institute cost-payors. The ability to control these costs is a tangential, but important, advantage of including drugs in a catastrophic package.

Some suggestions for cost controls follow.

1) A formulary would significantly help to control the cost of a prescription drug benefit. A formulary is simply a list of approved drugs for which reimbursement can be made under the program. This list, which can be compiled through an Institute of Medicine Consensus Conference or some other group of medical experts, would include drugs that were found safe, effective, and medically necessary in the treatment of various conditions. An exception process could be easily added for cases where a physician feels it necessary to prescribe an alternative drug to one that is on the list due to a patient's particular circumstance. Many of the nation's top hospitals already use formularies with ease and high levels of physician acceptance.

2) A maximum allowable cost (MAC) program, especially when coupled with a formulary, can significantly control costs. Many states, most notably New York, which has the largest prescription drug coverage program in the nation, successfully use a MAC system to control costs.

3) A MAC system can be put in place that would allow pharmacies to charge patients over the MAC limit and rely on competition to keep costs low. If pharmacies are excused from assignment under this option, we would urge that they be required to post lists of prices they charge for commonly required drugs within plain view of purchasers to encourage people to shop around. After all, it is easier and more likely that senior citizens will change drug stores on the basis of price than that they will change doctors.

4) Utilization review is an important element of keeping costs low and quality high. This will hopefully avoid the serious problem of over and duplicative prescribing. Perhaps Medicare peer review organizations could play a role in this area.

5) As another option, each senior could be required to select a pharmacy at the beginning of the year. Selected pharmacies would handle all prescriptions for that senior and notify HCFA when the deductible level has been reached. North Carolina successfully uses this type of approach. One clear advantage to this approach is that a single pharmacist is aware of all the drugs being prescribed by several doctors for one patient. This would greatly reduce the problem of duplicative prescribing, as well as mixing inappropriate drugs.

6) Competitive bidding could be used as a very important and potent form of cost control. Already used by the Department of Defense and the Veterans Administration in their prescription drug benefits, these two agencies invite bidding from qualified drug manufacturers. The price breaks available to these two major purchasers through competitive bidding are startling. In fact, when prednisone's wholesale price was $18.50 per hundred, the DOD was buying it for $0.73 for the same amount and from the same company.

7) Alternatively, a prescription drug benefit could be developed to address only the costs of drugs used in the treatment of chronic illnesses suffered most by the elderly, like arthritis, diabetes, cardiovascular disease, and cancer.

V. CONCLUSION

Mr. Chairman, this issue is not a new one. The specific coverage and administrative issues we're grappling with have been dealt with many times in the past. Not only do we have a body of knowledge to draw on from the states, we also have approximately 136 bills that have been proposed over the past 20 years to cover prescription drugs. Many of these proposals include formulary provisions, many include specific methods of cost containment, many include various arrangements of co-payments, deductibles, and financing. And still no action has been taken.

As a result, older people in 41 states still have no protection from these onerous costs. I urge the Congress to consider that reasonable solutions to many of these problems have been developed and proposed. The problems and solutions are not new.

The timing and possibility for action is the only new part of this debate. It is entirely possible and entirely warranted to include coverage of prescription drugs in the catastrophic package before us. We stand on the verge of doing the right thing, but seem a bit reluctant to take the plunge. On behalf of the 4.5 million members of the National Council of Senior Citizens, I urge Congress to enact such a proposal this year--going slowly as necessary, phasing in the proposal, and collecting additional data as we go along in a careful and measured way.

But, an opportunity for action missed on this issue this year will mean that we've missed the opportunity once again for true catastrophic reform of the sort for which seniors themselves are asking.

Item 3

Statement of the National Association of Retail Druggists

COVERAGE OF PRESCRIPTION DRUGS
UNDER MEDICARE

BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
100TH CONGRESS, 1ST SESSION
HEARING ON JULY 20, 1987
WASHINGTON, DC

NARD
205 Daingerfield Road
Alexandria, Virginia 22314

STATEMENT OF JOHN M. RECTOR

BEFORE THE SENATE AGING COMMITTEE

JULY 20, 1987

Mr. Chairman, Members of the Committee*:

I am John M. Rector. I serve as General Counsel and Vice President of Government Affairs of the National Association of Retail Druggists.

The National Association of Retail Druggists represents the owners of 30,000 independent pharmacies, where more than 75,000 pharmacists dispense 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide 82 percent of Medicaid pharmaceutical services. Over 60 percent of NARD's members provide home health care pharmacy services. NARD has long been acknowledged as the sole advocate for the proprietary and professional interests of this vital component of the free enterprise system.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

As owners, managers and employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to provide them a fair chance to compete. We appreciate the opportunity to appear before the Committee to present recommendations to be considered in the fashioning of Medicare Part B outpatient drug coverage.

We believe that a major strength of the health care system is the thousands of independent community pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare program should capitalize on the strengths of the existing retail distribution network for drugs, and related products and services.

---

* John Melcher (D-MT), Chairman
MAJORITY: (10-D) Senators Melcher, John Glenn (OH), Lawton Chiles (FL), David Pryor (AR), Bill Bradley (NJ), Quentin N. Burdick (ND), J. Bennett Johnston (LA), John B. Breaux (LA), Richard C. Shelby, (AL), and Harry Reid (NV)
MINORITY: (9-R) Senators John Heinz (PA), William S. Cohen (ME), Larry Pressler (SD), Charles E. Grassley (IA), Pete Wilson (CA), Pete V. Domenici (NM), John H. Chafee (RI), David Durenberger (MN), and Alan K. Simpson (WY)

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

We have approached the subject of today's hearing with considered reluctance. Not because we oppose the concept, in fact we support it. Our statement of positions addresses it as follows:

> "NARD supports the position that any national health insurance program adopted by the Congress include outpatient medications as an integral part of its benefits. Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice to obtain their prescription drugs. Pharmacies providing prescription medications should be compensated on the basis of the marketplace price for such products and services. Independent retail pharmacists should be assured a key role in the planning and development of any such drug program."

The source of our caution is predicated on the less than favorable experience that our members have had from the outset with the non-statutory Medicaid prescription drug program, and in recent years with the home health components of the Medicare program. We are concerned that a Medicare outpatient drug benefit program not replicate unsatisfactory aspects of the current Medicaid prescription drug program. Likewise, with more than 60% of our members involved with Medicare home health, it is critical that an outpatient drug coverage benefit be designed in a manner that will avoid the scandalous failure of Medicare to pay its participating providers in a timely, business-like manner, and avoid the constant barrage of arbitrary and inconsistent regulations dictated by HCFA.

More sophisticated aspects of program design become secondary, or even irrelevant, if when operational, appropriate resources are unavailable or if, as has been the policy of the current Administration, the government refuses to pay its bills promptly. Additionally, program continuity and stability is vitally important.

Fortunately, these especially severe Medicare cash flow problems, caused by the failure of HCFA and its agents to make timely payments, were addressed in the Omnibus Budget Reconciliation Act (OBRA) of 1986 by requiring that claims submitted for Medicare Part B Services be paid within 30 calendar days in FY 1987, 26 days in 1988, 25 days in 1989, and 24 days in FY 1990 and in subsequent years. We strongly support the initiatives on prompt payment, and as a member of the Prompt Payment Coalition, urge you to oppose all efforts to repeal the 1986 amendments.

This past October our House of Delegates unanimously passed a resolution calling for the establishment by law of the Medicaid prescription drug program reforms it has been advocating for more than a decade. Its full text is as follows:

WHEREAS, Congress never intended that the normal business practices of retail pharmacy such as earned discounts or marketplace pricing be placed in jeopardy, such as under MAC, EAC, PhIP and CIP, when a pharmacist serves patients in the Medicaid program; and

WHEREAS, the concept of a government discount, whether in the form of a discount off ingredient cost or a total charge, is totally unacceptable:

BE IT RESOLVED that NARD continue to oppose the concepts of a discount and instead, together with a coalition of pharmacy practitioners wholesalers, manufacturers and physicians, support the establishment by law of (1) marketplace pricing at the 90th percentile, and (2) a direct payment voucher system to reduce Medicaid administrative costs and assure prompt payment.

The two core themes of suggested reform: marketplace pricing and a direct payment system to reduce administrative costs and help assure that prompt payments are universally supported within the industry. In fact, National Association of Chain Drug Stores, Pharmaceutical Manufacturers Association, American Society of Hospital Pharmacists, American Pharmaceutical Association, National Wholesale Druggists Association, American Society for Consultant Pharmacists, and NARD all endorsed a document, "Principles for Reform of Medicaid Payment for Outpatient Drugs" in correspondence to HCFA's Administrator Roper on May 26, 1986. The principles, in our view, are equally applicable to the subject of today's hearing. Unfortunately, the Administration has not embraced them. We have provided the Committee with extensive information on these core ideas, including the NARD\Pracon study Marketplace Economics -- Alternatives in Medicaid Prescription Reimbursement (Oct. 1986). The full text of the "principles" follows:

PRINCIPLES FOR FEDERAL REFORM OF

PAYMENT FOR OUTPATIENT DRUGS

Following the implementation of the Medicaid program in 1965, pharmacists, more than other provider groups, enthusiastically supported and participated in this important health care program for the needy. Ten years later, in 1975, the Federal government adopted the Maximum Allowable Cost/Estimated Acquisition Cost program. This controversial approach established a complex set of formulas that imposed artificial controls on the retail marketplace and interfered with professional judgments regarding the selection of prescription drug products provided to the poor. In more recent years, the Medicaid program has been moving toward a reimbursement scheme that would further reduce reimbursement to pharmacies.

The Federal government seems content to capture limited, short-run savings at the expense of retail pharmacy providers and the research-intensive pharmaceutical manufacturing industry, while ignoring significant opportunities for reducing health care costs by allowing the competitive marketplace to function efficiently and effectively. In response, many prominent national organizations representing all components of the nation's drug distribution system--pharmaceutical manufacturers, drug wholesalers, independent pharmacies, chain drug stores, hospitals and the pharmacy profession--have been advocating a complete overhaul of the Medicaid drug reimbursement system. These organizations are calling for less government intrusion, so that the nation's pharmacies can continue to provide the highest standard of care and service to needy people.

FUNDAMENTAL PRINCIPLES

Reduce needless federal regulation. American society experienced a virtual explosion in Federal Government regulation during the past decade. Between 1970 and 1979 the number of pages published annually in the Federal Register nearly tripled and the number of pages in the Code of Federal Regulations increased by over two-thirds. The current Medicaid drug program was part of this growth.

Although well-intended when originally developed, the Medicaid drug program has failed to keep pace with rapid changes in health care delivery over the past ten years. This has resulted in pharmacy providers subsidizing the Medicaid program because they frequently lose money when they fill a Medicaid prescription. Moreover, the hardship and uncertainty imposed on business by this over-regulation has impeded business decisions and expansion plans, ultimately reducing economic growth and the creation of jobs in the private sector. This over-regulation is particularly burdensome to small and independent businessmen and women, such as pharmacists who are proprietors of community pharmacies, and causes them to defer or terminate plans for expansion.

Our position on Medicaid drug reimbursement is directed at minimizing governmental intrusion by reforming or eliminating regulations which are unnecessary and counterproductive.

Improve administrative practices. Approximately 171 million claims are processed each year by the Medicaid program. Wasteful administrative overhead consumes resources that should be targeted on the health needs of beneficiaries. Furthermore, current inefficient administrative practices impose needless hardship on retail pharmacies due to slow and erratic payment and excessive paperwork. Initiatives to improve administrative practices can reduce both public and private costs to process Medicaid claims, and insure timely payment to pharmacies.

Rely on the marketplace. We do not need excessive Federal regulation to solve the problems of Medicaid drug costs. As long as we let the forces of the marketplace work without undue interference, the ingenuity of consumers, businesses, producers and inventors will do that for us. The retail drug market is dominated by self-pay customers who, along with increasingly cost-conscious third party payers, impose competitive discipline on marketplace prices. If we allow it to, the magic of the marketplace will unleash new competition, giving the Medicaid program lower prices, and Medicaid beneficiaries more choices and better services.

To achieve meaningful reform, public policies governing the Medicaid drug program should be revised along the following lines:

- *Base drug reimbursement on sound economic principles through the elimination of artificial controls. This would be achieved by replacing the current provisions governing reimbursement with marketplace pricing, i.e., usual and customary charges for all products and services, capped, for example, at the 90th percentile for all charges within a state.*

- *Implement a new and streamlined reimbursement mechanism that would greatly lower administrative expenses in the program. Such a worthwhile objective can be easily accomplished by coupling marketplace pricing with an innovative system of drug vouchers.*

States shall build upon this basic set of principles established by the Federal Government, tailoring their individual programs to fit local circumstances.

ADDITIONAL RECOMMENDATIONS

Additionally, we recommend that the Committee seriously consider the following:

a) The reinstatement of the 60 day or longer public notice for changes in the Medicare reimbursement method or level of reimbursement for the prescription drug program;

b) Interest and penalties for late payments;

c) An administrative fee for the extra cost of processing or transferring Medicare forms;

d) Inclusion of both short and long term I.V. antibiotic products and services;

e) Require and reimburse for pharmacist consultation. Face to face communication between patient and pharmacist has been a vital component of pharmacy practice since its inception. Pharmacists interact daily with patients in their stores; they monitor their patients' health status, assess their compliance with drug therapy, answer questions, make recommendations, and communicate with their physicians. Patients know they can count on the pharmacists to provide expert advice on drug therapy on the spot and personally attend to their individualized health care needs. This interpersonal communication is an especially key element for Medicare eligible persons.

f) Reject suggestions to confiscate the discounts that pharmacists earn. Discounts extended to pharmacists on drug purchases from manufacturers or wholesalers as rewards for prompt payment, prudent purchasing, and other sound business practices are an earned portion of the pharmacist's business income. Such discounts are earned by pharmacists for operating their businesses efficiently. They serve as incentives to help a business to prosper and to continue to serve patients in the community.

g) If copayment is established, require that it be mandatory. More than 60% of our members' sales are for prescription drugs, 10-15% of our members sell only prescription drugs. They rarely "loss lead" prescription drugs and would be placed at a decided competitive disadvantage if the copay is not mandatory. Equally problematic are the copay forgiveness aspects of the Medicaid program for select beneficiary groups.

h) To address the problem of tax-exempt competitors, consider adopting provisions similar to OMB Circular A76 for bidding on federal contracts which, to assure a level playing field, requires the advantages of nonprofit status to be reflected. This should be reflected in reduced payment to any eligible nonprofits.

i) Require that manufacturers eliminate multitier pricing policies for prescription drugs, or in the alternative, permit independent retail druggists to acquire for Medicare purposes the drug products under the same pricing structure available to non-profit entities.

j) Review the present reimbursement for prescription drugs under Medicare Part A with an eye to determining present cost to the government in contrast to cost in the prescription drug retail marketplace.

k) Consider, as the Energy and Commerce Committee has recommended in its Oversight Subcommittee Report "Dangerous Medicine"(May 1986), denying Medicaid and Medicare funds to hospitals and other health care institutions convicted of diverting prescription drugs.

l) Consider a provision to assure that nonprofit purchasers of prescription drugs utilized in the Medicare programs comply with the 1938 Nonprofit Institutions Act. This Act permits price discrimination for purchases by true charities. We recommend that an appropriate standard would be the percent of uncompensated care provided by the nonprofit entity coupled with bad debt.

m) Include a provision that would limit physician dispensing to rare rural remote circumstances when it can be demonstrated that a pharmacy is not available. Prescription drug samples which were retained under the provisions of H.R. 1207, (which passed the House of Representatives on May 4, 1987, after having been unanimously reported by the Energy and Commerce Committee, which with S. 368, was the subject of a hearing on 6-15-87 of this Committee's Trade Subcommittee) are available for any true emergency when a 24-hour pharmacy emergency number, which is common, is not available.

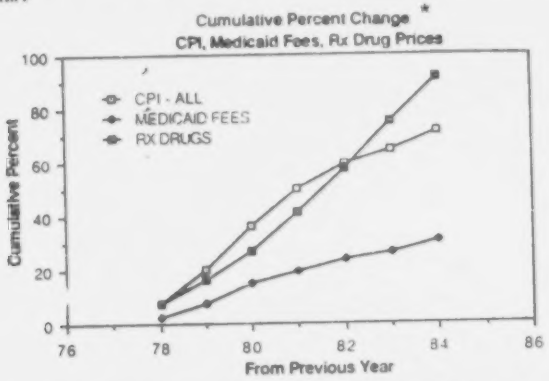
n) Consider the profit guaranteed to entities that are awarded contracts to administer state Medicaid prescription drug programs and Medicare fiscal intermediaries when attempting to establish an appropriate level for pharmacy providers.

o) Consider the prescription drug benefit program that Marion Laboratories, Inc., Kansas City, Missouri, has established for its employees. It is based on marketplace pricing and rejects the cumbersome arbitrarily fixed dispensing fee. It reflects the variety of professional services, and importantly, it has helped contain the cost of the prescription drug benefit coverage that Marion established for its employees.

COMMENTS ON MEDICARE CATASTROPHIC PRESCRIPTION DRUG LEGISLATION OF 1987

We support the effort to provide appropriate Medicare outpatient prescription drug coverage and would characterize this legislation, as we have that developed by the Chairman of the Health Subcommittee of Energy and Commerce, namely, a giant step forward.

We cannot stress too much, however, our very real concerns that the shortfalls and disasters for pharmacy providers, especially under the non-statutory laissezfaire Medicaid program, not taint the excellent opportunity which the Committee has to address the drug needs of the elderly. The following chart effectively demonstrates one of the major problems our members have experienced under the Medicaid Prescription Drug Program.



In 1977 the average unweighted dispensing fee for all states was $2.46. This fee had increased to $3.21 in 1984, representing an increase of only 30.4 percent for the eight year period. During this same period, the Consumer Price Index for all items had increased 71.2 percent, and the cost of prescription drugs to the consumer increased 91.2 percent.

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* *"Pricing of Pharmaceuticals: An Independent Community Pharmacy Perspective" by D.C. Huffman, Jr., Ph.D., et al. Presented to the Second Annual Conference on Pharmacy Policy Issues at the Hubert Humphrey Institute, University of Minnesota, 1987.*

We have three general observations which are made in a constructive vein, each of which relate to the need for fundamental fairness in whatever program is designed. Although we prefer a marketplace pricing standard, if the Committee is intent upon setting our prices, you must address the prices of others participating in the program over which the pharmacist has no control.*

1) We have no control over manufacturers' prices. One approach under the Waxman bill, for example, would be to require manufacturers to submit prices to the Secretary twice a year in conjunction with the "calculation period", e.g. October 1/April 1. They would guarantee such prices for that period, just as is the case presently for Medicare inpatient prescription drugs. We should not continually take a bad rap from the public, especially the needy and elderly, for the price of prescription drugs over which we have no control.

2) Hospital reimbursement for inpatient prescription drugs under Medicare similarly should be on the same terms as Medicare outpatient drugs. If cost-plus based reimbursement is rejected for outpatients, it should be rejected for inpatients and comparable cost-control mandated for both hospital settings, for example, an average wholesale hospital cost (AWHP) could be developed by the Secretary.

3) Likewise, those entities which would administer the Medicare outpatient drug program should be subjected to comparable cost controls. Such criteria should be specified in the determination of the actuarial rate.

Among our specific comments on various recent legislative proposals are the following:

1) We support the 20% co-insurance cost-sharing provision with perhaps a flat fee on single source drugs.

2) Regarding a $4.50 administrative allowance for the pharmacists, we recommend the automatic annual application of an index.

3) A national formulary could prove to be complex and costly to operate. In any case, the details of the formulary should be, to the extent possible, expressed in the statute and/or the committee's accompanying reports. Additionally, it's important in our view, that the Secretary be required to consult with individuals of recognized professional standing and distinction in the fields of medicine, pharmacology and pharmacy. In fact, if a national formulary is established, it is essential in our view that a statutory formulary committee be set up that would establish the appropriate involvement of such individuals.**

* See attached copy of price list and flow chart.
** See attached copy of 1972-73 Senate Finance Committee bill on Medicare outpatient drug coverage providing for a formulary.

4) We support provisions which would encourage electronic billing and other cost-effective direct payment mechanisms, i.e., voucher and smart cards. If such systems are mandated, we suggest flexibility for rural areas. Perhaps the definition of rural recently developed in conjunction with the authorization increasing the speed limit to 65 m.p.h. would be appropriate.

5) We recommend that Medicare payment be limited to a 34-day supply or 100 dosage units, whichever is greater. Recent studies, including that by the Pharmaceutical Data Services, documented the phenomenon known in the trade as "wastage" -- the percentage of prescription drugs filled but not used when more than this supply is authorized. The International Ladies Garment Workers Union is typical of the plans which permit its members to buy only a 30-day supply because of wastage.

We have endorsed on substantive and pragmatic grounds the compromise bill, H.R. 2941, recently approved by the House leadership and likely to be considered by the House later this week.

It's important to emphasize that the national Pharmacy Services Administrative Organization (PSAO) movement and other developments have brought independent pharmacies to the point that the recordkeeping required in the various proposals to monitor expenditures by Medicare beneficiaries is readily achievable.

CONCLUSION

NARD seeks the support of the Committee for our recommendations and will assist its members and staff in the refinement of your proposals.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear and continue to participate in the formulation of Medicare Part B outpatient prescription drug coverage.

PHARMACEUTICAL DIVERSION

EXHIBIT 1

PRODUCT ANALYSIS BY TIER PRICING

Product	AWP ($)	Contract ($)
Tylenol tabs., 325 mg., 1000	32.54	2.84
Proventil inhaler, each	9.18	2.95
Omnipen-N, inj., 1g., 10s	148.69	35.70
Velosof, 250 mg. caps., 100s	38.71	14.80/10
Lotrimin 1% cream, 15 g. each	5.27	.99
Garamycin, 80 mg./2 ml. inj.	84.50	10.20
Alupent tabs., 10 mg., 100s	12.22	2.99
Depo-medrol, 40 mg. inj.	4.95	2.30
Transderm Nitro, 2.5 mg.	28.70	.30
Nilstat Susp., bowel	13.84	1.78
K-Lor, 15 mg., 100	28.58	3.50
K-Tab, 10 mg., 100	10.44	.62
Kaon-ce tabs, 100	9.49	3.00

Reference: Statement of Eddie Ronald Burklow before the House Subcommittee on Oversight & Investigations, Committee on Energy & Commerce, September 19, 1985

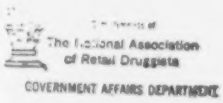
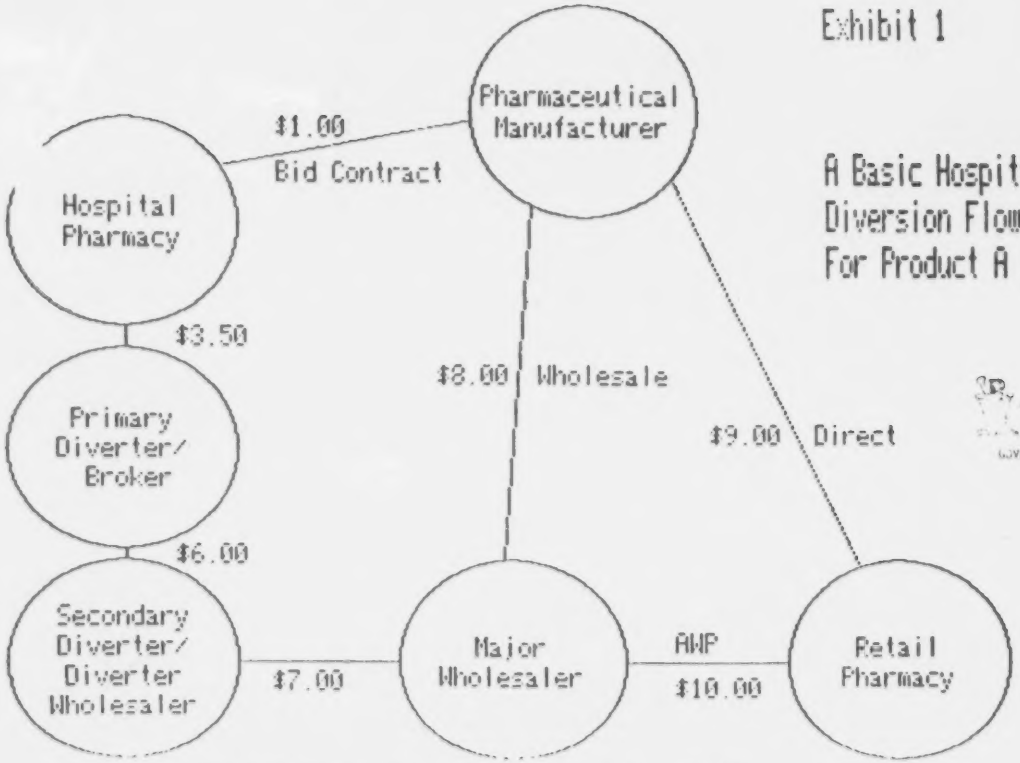


Exhibit 1



A Basic Hospital-Type Diversion Flow Chart For Product A

Compliments of
The National Association of Retail Druggists
GOVERNMENT AFFAIRS DEPARTMENT

Exhibit 2

Coverage of Certain Maintenance Drugs Under Medicare

(Sec. 215 of the bill)

BACKGROUND

The committee added an amendment to the House bill which would provide coverage of certain maintenance drugs under part A of medicare. Medicare presently covers the cost of drugs given to an inpatient in a hospital or extended care facility, but does not, however, pay for prescription drugs on an outpatient basis.

Beneficiaries and others have frequently indicated the lack of coverage for outpatient drugs as the most significant gap in the medicare benefit structure. Prescription drug expenses account for a large part of the health expenses of older people. More important, perhaps, than the fact that drugs represent a large out-of-pocket expense for the elderly is that this expense is distributed unevenly among the elderly. Those with chronic illnesses such as heart or respiratory diseases are often faced with recurring drug expenses and many of these drugs are critical to the survival of these chronically ill patients. As a result, the elderly with chronic illnesses have, on the average, prescription drug expenditures nearly three times as high as those without chronic illnesses.

The committee believes that an outpatient prescription drug benefit is the most important and logical benefit addition to the Medicare program. However, the committee was quite concerned with the cost and administrative problems associated with proposals to cover all outpatient prescription drugs under medicare. Covering all drugs for the aged and disabled, with a $1 copayment, was estimated by the Social Security Administration to cost about $2.6 billion. In addition, the administrative burden of covering all drugs would be enormous since the program would have to deal with millions of small prescriptions, and the utilization controls to assure that prescriptions reimbursed under medicare were reasonable and necessary and used only by beneficiaries, would be quite cumbersome.

In studying the problems posed with respect to establishing an outpatient drugs benefit, the committee concluded that the problems could in large part be surmounted by an approach which focused on provid-

ing specified drugs which are necessary for the treatment of the most common crippling or life-threatening chronic diseases of the elderly. This approach would have four advantages: (1) It would result in the medicare dollar being targeted toward patients with chronic diseases who need drugs on a continuing basis for a lengthy period of time; (2) it would substantially simplify administration of a drugs benefit; (3) it would incorporate almost self-policing utilization controls at a relatively low administrative cost, since the program would involve only a relatively small number of drug entities and the necessity for these drugs would be comparatively easy to establish; and (4) this approach would substantially lower the cost of providing a drugs benefit. The cost of the amendment is estimated at $740 million for the first full year beginning July 1, 1973.

The committee approach is consistent with the recommendation of the Task Force on Drugs of the Department of Health, Education, and Welfare. The Task Force, in accordance with the Social Security Amendments of 1967, undertook many months of study concerning the appropriateness and possible methods of covering drugs under medicare. In their final report, issued in February 1969, the Task Force stated:

> "Available data on drug use by the elderly support the hypothesis that coverage of only those drugs which are important for the treatment of chronic illness among the elderly, and which usually are required on a continuing or recurring basis, would concentrate the protection provided by a drug program where it is most clearly needed."

After reviewing the relative advantages of this approach, the Task Force recommended:

> "In order to achieve maximum benefits with whatever funds may be available, and to give maximum help to those of the elderly whose drug needs are the most burdensome, the Task Force finds that particular consideration should be given to providing coverage at the outset mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness."

The committee commends the Task Force for its exhaustive and definitive efforts and agrees with its recommendation.

Summary of Committee Amendment

Basically, the committee amendment would provide specific drugs necessary for the treatment of the many crippling or life-threatening diseases of the elderly with the beneficiary subject to a copayment of $1 per prescription.

The chronic illnesses covered under the amendment were carefully chosen. The Task Force on Prescription Drugs issued a voluminous study containing extensive data with respect to drug utilization among the elderly. The table below, taken from the Task Force report, lists the more common chronic illnesses of the elderly, in order of the number of prescriptions related to each condition.

DESCENDING ORDER FOR NUMBER OF PRESCRIPTIONS USED IN TREATMENT OF ILLNESSES AMONG THE AGED

[Excluding mental conditions, gastrointestinal disorders, chronic skin diseases and anemia]

Diagnosed Conditions	*Number of Rx's in thousands*
Heart	46,512
High blood pressure	19,681
Arthritis and rheumatism	17,343
Genito-urinary conditions	9,127
Diabetes	8,085
Colds, coughs, throat conditions and influenza [1]	7,504
Other disorders of circulatory system	4,776
Injuries and adverse reactions [1]	4,000
Neoplasm	3,701
Eye	3,683
Emphysema	2,766
Asthma and hay fever	2,547
Other respiratory conditions	2,415
Sinus and bronchial conditions	2,138
Ear	2,113
Pneumonia	1,531
Thyroid	1,491

[1] Not included in amendment because of generally short-term nature of condition and need for prescriptions.

The amendment would cover serious chronic conditions necessitating long-term drug treatment with the exception of mental and nervous conditions, chronic skin disease, anemia, and gastrointestinal disorders. These diagnoses are excepted because many of the drugs used in their treatment (for example, tranquilizers, antacids, antispasmodics, antidiarrheals, vitamins, iron, and skin ointments) are drugs which are also used by many people for general reasons and are, therefore, difficult to confine to appropriate usage by beneficiaries only (for example, they could be acquired for use by nonbeneficiaries) as opposed to drugs such as insulin or digitalis which are almost invariably used only by those who have a specific need for them. In addition, concern has been expressed that coverage of the "major" tranquilizers used in the treatment of mental illnesses might encourage over-prescribing of potent tranquilizers for older people.

The amendment would further limit coverage to only certain drugs used in the treatment of covered conditions. In other words, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and other drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs generally used by people without heart conditions. However, other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The provision is designed to establish a basis for coverage of drugs capable of administration at reasonable cost. In this form and scope

it is an approach capable of providing significant help and of allowing for orderly future expansion if that were later decided.

It is expected that the Formulary Committee will study the problems related to the question of possible medicare coverage of drugs used in the treatment of mental illness with particular attention to development of means of assuring appropriate usage of such drugs. The Formulary Committee would submit to the Congress, through the Secretary, a report concerning its findings, conclusions and recommendations with respect to this matter.

Eligibility

All persons covered under part A of medicare would be eligible for the new outpatient drugs benefit. Under the provision, the drugs covered are necessary in the treatment of the following conditions:

- Diabetes
- High blood pressure
- Chronic cardiovascular disease
- Chronic respiratory disease
- Chronic kidney disease
- Arthritis and Rheumatism
- Gout
- Tuberculosis
- Glaucoma
- Thyroid disease
- Cancer
- Epilepsy
- Parkinsonism
- Myasthenia gravis

The fact that the patient needs the drug would indicate that he suffers from one of the above illnesses. Thus generally the existence of a specific chronic illness would not have to be established in connection with the application for payment for the prescription.

Benefits

The covered drug therapeutic categories are as follows:

- Andrenocorticoids
- Anti-anginals
- Anti-arrhythmics
- Anti-coagulants
- Anti-convulsants (excluding phenobarbital)
- Anti-hypertensives
- Anti-neoplastics
- Anti-Parkinsonism agents
- Anti-rheumatics
- Bronchodilators
- Cardiotonics
- Cholinesterase inhibitors
- Diuretics
- Gout suppressants
- Hypoglycemics
- Miotics
- Thyroid hormones
- Tuberculostatics

Within these categories, eligible drugs would be those prescription drug entities which are included by dosage form and strength in the Medicare Formulary described below. The amendment would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used for a short period of time and drugs such as tranquilizers and sedatives which may be used not only by beneficiaries suffering from serious chronic illnesses, but also by many other persons as well. Beneficiaries would incur a $1 copayment obligation for each prescription. They would also be

obliged to pay any charges in excess of the product price component of the reasonable allowances where a higher-priced product of a drug included in the Formulary was prescribed and where the allowances were based upon generally available lower cost products (see "reasonable allowance" below). Payment under this program would not be made for drugs supplied to beneficiaries who are inpatients in a hospital or skilled nursing facility because their drugs are already covered under medicare.

Formulary Committee

To assure rational and professional control over the drugs covered and the cost of the drugs benefit, and to assure that funds are being targeted toward the most necessary drug entities within each covered therapeutic category, a Medicare Formulary would be established.

The Formulary would be compiled by a committee consisting of five members, a majority of whom would be physicians. The members would include the Commissioner of Food and Drugs and four individuals of recognized professional standing and distinction in the fields of medicine, pharmacology or pharmacy who are not otherwise employed by the Federal Government and who do not have a direct or indirect financial interest in the economic aspects of the committee's decisions. Members would be appointed by the Secretary for 5-year staggered terms and would not be eligible to serve continuously for more than two terms. The Chairman would be elected by and from the public members for renewable one-year terms.

It is expected that appointees to the Formulary Committee will have the stature and expertise to assure objective effort and informed decision-making of a level engendering public and professional confidence in their integrity and judgment.

The Formulary Committee would be authorized, with the approval of the Secretary, to engage or contract for such reasonable technical assistance as it determined it might need from time to time to enhance its capacity for judgment concerning inclusion of drugs in the Formulary. This could include utilizing the services of the committees and technical staff of the official compendia (the United States Pharmacopeia and the National Formulary). The committee expects that such contracting would be undertaken on a limited ad hoc basis, and will be used to supplement, as necessary, the services available within the Department.

The Formulary Committee's primary responsibility would be to compile, publish, and revise periodically a Medicare Formulary which would contain a listing of the drug entities (and dosage forms and strengths) within the therapeutic categories covered by the program which, based upon its professional judgment, the committee finds necessary for proper patient care, taking into account other drug entities included in the Formulary. To aid fully its consideration as to whether a drug entity should be included in the Formulary, the Formulary Committee would be authorized to obtain any records pertaining to a drug which were available to any other department or agency of the Federal Government and to request of suppliers of drugs and other knowledgeable persons or organizations pertinent information concern-

ing the drug. The committee would be authorized to establish procedures which it might require to determine the appropriateness of including or excluding a given drug from the Formulary.

The Formulary Committee would exercise utmost care in maintaining the confidentiality of any material of a confidential nature made available to it.

For purposes of inclusion in or exclusion from the Formulary of any drug entity (in a given dosage form and strength), the principal factors to be taken into account by the committee would be: (1) Clinical equivalence, in the case of the same dosage forms in the same strength of the same drug entity; and (2) relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category. The price of a drug entity would not be a consideration in the judgment of the Formulary Committee.

In considering which drug entities and strengths, and dosage forms, to include in the Medicare Formulary, the Formulary Committee is expected, on the basis of its professional and scientific analysis of available information, to exclude such drugs as it determines are not necessary for proper patient care taking into account those drugs (or strengths and dosage forms) which are included in the Formulary.

For example, in their consideration of drug entities in the therapeutic category known as anti-anginals, a therapeutic category included in the covered categories, the Formulary Committee would be expected to take into account professional appraisals such as the following which appears in "Drug Evaluations—1971," an authoritative publication of the American Medical Association:

> "The effectiveness of the short-acting agents, such as nitroglycerin and amyl nitrite, has been established through many years of use. * * * The oral administration of the so-called 'long-acting nitrates e.g., pentaerythritol tetranitrate, . . . erythrityl tetranitrate, . . . isosorbide-dinitrate, as well as some preparations of nitroglycerin are alleged to reduce the number of episodes and the severity of the pain of angina pectoris. The effectiveness of these agents is even more difficult to determine than that of the short-acting nitrates, and thus the beneficial value of their long-term use is controversial. * * * Thus, it cannot be concluded that the long acting nitrates are of definite therapeutic value for prolonged use.
>
> "Many products are available that contain a mixture of antianginal agents or an antianginal agent with a sedative or other drug(s); however, none of these fixed-dose combinations is rational. There is no evidence that a combination of antianginal agents has any advantage over the individual agents and, if more than one type of drug is needed, they should be prescribed separately."

The above quotation is illustrative of the type of source and information to which the Formulary Committee is anticipated to give serious consideration and weight in determining those drug entities (and dosage forms and strengths) which are reasonably appropriate as eligible drugs for purposes of medicare reimbursement.

Prior to removing any drug entity (or a particular dosage form or strength) from the Formulary, the committee would afford reasonable opportunity for a hearing on the matter to persons engaged in manufacturing or supplying the drug involved. Similarly, any person manufacturing or supplying a drug entity not included in the Formulary, but which he believed to possess the requisite qualities for inclusion, could petition the committee for consideration of the inclusion of his drug and, if the petition was denied, might, at the discretion of the committee, upon reasonable showing to the Formulary Committee of ground for a hearing, be afforded a hearing on the matter.

In addition to the list of drug entities included in the Formulary, the Formulary would also include a listing of the prices (generally the average wholesale prices) at which the various products of the drug entities are usually sold by suppliers to establishments dispensing drugs.

The Formulary Committee would be solely responsible for professional judgment as to which drug entities (and dosage forms or strengths) are included in the Formulary. The Secretary would not be involved in the making of those professional determinations.

Reimbursement

Reimbursement would be based, generally, on the average wholesale price at which the prescribed product of the drug entity included in the Formulary is sold to pharmacies plus a professional fee or other dispensing charges, except that reimbursement could not exceed an amount which, when added to the copayment required of the beneficiary, exceeded the actual customary charge at which the dispenser sells the prescription to the general public.

Both components of the reimbursement would be subject to overall limitations just as medicare's reimbursement to physicians, hospitals and other suppliers is subject to overall limitations. The professional fee or other dispensing charge would not be recognized for medicare reimbursement purposes to the extent that it was in excess of the 75th percentile of fees or charges for other pharmacies in the same census region. In establishing the 75th percentile limit in an area where some pharmacies use one system of calculation and others use a different system, it is the intent that the 75th percentile of charges be calculated independently for the two systems only where a substantial number of pharmacists in an area used each of the methods of charging for dispensing costs. Otherwise, use of the percentile would have the result that a scattering of pharmacists using a given form could set their own limit which might not be reasonable in relation to the usual practices in a community. In order to avoid this undesirable effect, where only a few pharmacists in an area used a given form of dispensing charge, the limit on this charge would normally be set at a level essentially equivalent to the 75th percentile for the form of dispensing charge most frequently used by pharmacists in an area. In determining the 75th percentile, pharmacies with a lesser volume of prescription business would be compared with each other and all larger volume pharmacies would be similarly compared with each other.

Increases in the prevailing professional fees or other dispensing charges would be recognized in a manner similar to recognition of

increases in prevailing physicians' fees. That is to say, increases in prevailing fees or dispensing charges could be recognized (not more than annually) up to limits established for program purposes by factors based upon changes in costs of doing business and average earnings levels in an area during a given period of time. A given pharmacy could change from a professional fee to another dispensing charge basis or vice versa, but for program reimbursement purposes the net effect of such change should be neutral.

Program payment for the drug entity (in given dosage forms and strengths) would be limited to reasonable allowances determined by the Secretary on the basis of the average wholesale prices at which the various products of the drug entity (in a given dosage form and strength) are commonly sold to pharmacies in a region plus the professional fee or dispensing charge. The beneficiary would be obligated to pay $1 of the reasonable allowance. If there was only one supplier of a drug entity, the price at which it was generally sold (plus the fee or dispensing charge) would represent the reasonable allowance. If, however, several products of the drug (in the same strength and dosage form) were generally available, reasonable allowances would be established which would encompass the lower priced products which were generally available and sold to pharmacies in a region. The number of lower priced products selected would stop at the point where reasonable availability of the drug entity is assured. In the latter case, other products of the drug entity (in the covered dosage form and strength) could also be reimbursable—even though not specifically included in the range of lower-priced products where the average wholesale price of any such product was at or below the point used by the Secretary in establishing a reasonable allowance. This procedure avoids the problem of having to list every eligible drug product falling within the range of acceptable supplier prices in order for it to be reimbursable.

Products of a drug entity included in the Formulary which are priced above the highest reasonable allowance would be reimbursable but only to the extent of the highest reasonable allowance. The beneficiary would be obligated to pay the excess cost.

There would be three circumstances under which the program payment for a prescription could exceed reasonable allowances. First, if the supplier of a given drug product (of a drug entity in a strength and dosage form included in the Formulary) can demonstrate to the Formulary Committee that his product possesses distinct therapeutic advantages over other products (of the same dosage form and strength) of that drug entity, then the reasonable allowance for that drug product would be based upon the price at which it was generally sold to pharmacies. Second, where the Formulary Committee believed there was legitimate question concerning the clinical equivalency of the various products of different suppliers of a covered drug entity (or of given dosage forms and strengths) the Formulary Committee would be expected to list all of the products of the covered drug entity (in the dosage forms and strengths in question) so as to provide the prescriber with complete discretion until such time as the matter was resolved. Thus, the reasonable allowance would be based upon the reasonable customary price to the pharmacy for the product prescribed by

the physician in such cases. Third, if the physician felt in a specific instance that a particular manufacturer's product of a drug entity included in the Formulary, but which was priced above the highest product price component of the reasonable allowance, provides superior therapy to his patient and if he prescribes that product in his own handwriting by its established name and the name of its supplier, the reasonable allowance for the product would be based upon the price at which it was generally sold to pharmacies. Thus, a physician's reasonable discretion to prescribe a particular product of a drug entity included in the Formulary would be accommodated. In such cases, however, the reasonable allowance would not be greater than the actual usual or customary charge at which the pharmacy sells that particular drug product to the general public. The committee expects that these unusual prescribing situations will occur in only a small percent of cases, and this procedure would not negate the overall medicare requirement that services be reasonable and necessary. The Professional Standards Review Organizations (or, in the absence of a PSRO, other appropriate professional review), would be available to routinely review prescribing practices.

In circumstances other than those described above, where the cost of the drug product prescribed by the physician exceeds the highest product price component of the reasonable allowance, the beneficiary would be liable for charges to the extent of this excess including any related dispensing fee or charge.

Ordinarily, however, the beneficiary's obligation would be $1 per prescription, with the program paying the balance to the pharmacy.

Reimbursement to providers participating under medicare for other than the drugs program (such as hospitals) would be made on the regular reasonable costs basis.

In the case of insulin, reimbursement would be made to a pharmacy for its reasonable, usual and customary charge to the general public, plus a reasonable billing allowance less the $1 copayment.

Reimbursement would generally be made only to participating pharmacies. The exception would be that payment may be made for covered drugs dispensed by a physician where the Secretary determines that the drug was required in an emergency or that no pharmacy was reasonably available in the area.

Participating Pharmacies

As mentioned above, reimbursement under this program would be limited to participating pharmacies. No program reimbursement would be made either to the beneficiary or to a pharmacy where the prescription was dispensed by a non-participating pharmacy. The use of participating pharmacies would substantially decrease the administrative costs of the program, as participating pharmacies would generally submit batches of prescriptions and the program would not need to reimburse individual beneficiaries on a prohibitively costly prescription-by-prescription basis.

Such pharmacies would have to be licensed (where required) in the State in which they operate and would have to meet conditions of participation established by the Secretary of Health, Education, and Welfare. Participating pharmacies would file with the Secretary

a statement of their professional fee or dispensing charges (including minimum charges) as of June 1, 1972, so that the Secretary could determine the initial prevailing fee or charges in the census region for purposes of calculating reasonable allowances.

Participating pharmacies would agree to accept medicare reimbursement as payment in full and would further agree not to charge the beneficiary more than $1 copayment (except to the extent that a product prescribed by a physician was one whose cost exceeded the reasonable allowance).

The participating pharmacy would be paid directly by medicare on a prompt and timely basis with respect to eligible prescriptions submitted. The prescriptions from each pharmacy would be audited from time to time, on a sample basis to assure compliance with program requirements.

ADMINISTRATION

The committee amendment has been structured in such a way as to simplify and facilitate provision of and payment for benefits.

However, the committee has chosen not to specify a particular method or mold of administration. Because this is a new benefit, it is difficult to forecast which methods or organizational structures might most suitably implement the committee's intent that the drugs benefit be administered in the most efficient, expeditious and economical fashion. Fulfillment of the committee's intent would not necessarily entail uniform organization and procedures in each region. The Secretary could find that different means of administration in different regions or areas were appropriate in achieving the administrative objectives of the committee.

HEALTHY OLDER PEOPLE

OCTOBER 1986: Talk About Prescriptions Month

Tips on How to Use the Healthy Older People Program During the Upcoming National Observance

Steven R. Moore, R.Ph., M.P.H.

During the last two years, the U.S. Public Health Service has organized a national health effort for older Americans called Healthy Older People. A variety of print and broadcast materials have been developed for older people that promote healthy behaviors, including the safe use of medications.

Healthy Older People is based upon market research that indicates that older people are actively seeking reliable sources of health information and are willing to change their behavior in order to maintain good health. The materials outline simple steps older adults can take to improve their lifestyles and their health. These materials include skill sheets, posters, media kits, radio and TV public service announcements, and preproduced radio and TV news segments.

Excellent opportunity

October is Talk About Prescriptions Month, which provides you with an excellent opportunity to use the Healthy Older People materials to encourage older adults to use medicines safely. The messages urge older adults to ask their pharmacists and doctors questions and to keep a medication schedule.

To take advantage of this opportunity, the first thing you should do is contact your state contact for Healthy Older People, who has been appointed by the governor. The contact can discuss the availability of the various materials that have been developed for your use. To find out your contact's name, see the listing at the end of this article or phone the national hotline for Healthy Older People, 1-800-626-5433.

The television public service announcements (PSAs) or the TV news segments are good materials for local television stations interested in highlighting the health promotion topics or in doing special interest news series on geriatric drugs during October. However, due to competition for air time and the time involved to promote such an effort, you'll need to consider how much time you have to devote to this particular effort.

Contacts in each state can assist you with your promotional efforts

Information on the safe use of medicines should also be distributed to local newspapers since older people read newspapers regularly. Press packets have been mailed to state contacts that contain newspaper copy for editorial pages, a column on the safe use of medicines written by the U.S. Surgeon General that points out the critical role of the pharmacist in this area, and other factual information that reporters can use to write a story. Don't hesitate to link the effort with the Healthy Older People logo in your newspaper advertisement copy, especially if you will be following up with specific print materials to be distributed at your store.

In-store promotion

In addition to these materials, several other print materials including skill sheets, medication schedules, and personal medication records, have been developed for use in your store. These can be photocopied or reprinted, each with space for adding your store identification or logo, and distributed at your prescription department check out. You could also reproduce them on dispensing bags or use them as bag stuffers. These materials are suitable for wide distribution, not only to customers, but also through community outlets and local government providers that service older consumers.

The elderly are a natural focus for your education and promotion activities this October

Pfizer Pharmaceuticals will also supply a complimentary loan copy of its geriatric health promotion film "We Still Are," which comes complete with copies of several Healthy Older People print materials, in-

Steven Moore is senior advisor on geriatric drugs for the Office of Disease Prevention and Health Promotion, U.S. Public Health Service, Department of Health and Human Services, Washington, DC.

77-493 0 - 87 - 6

cluding the skill sheet, personal medical record, and medication schedule, for audience distribution. To obtain the film, write Pfizer Pharmaceuticals, P.O. Box 168, Staten Island, NY 10305.

Be sure to coordinate your efforts with others that may already be under way. Your local or state pharmacy association, for example, may have activities planned, which would make your media efforts easier because they would benefit all the pharmacists in the area, not just your store.

You might consider joint sponsorship of several special activities, including:

- a "brown bag" clinic, where seniors bring all of their medications in a bag for inspection and recommendations are made on items to discard or discontinue
- a blood pressure or glaucoma screening effort
- a health fair
- a special program at a retirement community or with a senior citizens club

Additional ideas and help in organizing your efforts can be obtained through your state coordinator or the national hotline for Healthy Older People. Schools of pharmacy may also help you plan and carry out such activities, as well as provide externs who are doing clinical or community rotations or other student volunteers.

The long-term positive benefits of getting included in an activity of this sort should more than compensate for the time and effort you put into it. Do your homework so you are able to make the proper promotional effort to benefit both you and your customers. Carefully analyze the quantity of materials that you will need so you'll have adequate supplies. Think also about evaluating your effort, even subjectively, to aid you in similar future efforts. Try to analyze what succeeded and what didn't.

Special promotions for older Americans not only provide a valuable service to these important customers, they also give you the opportunity to participate in Talk About Prescriptions Month in a meaningful way. The Healthy Older People materials can be an important aid to you in this effort.

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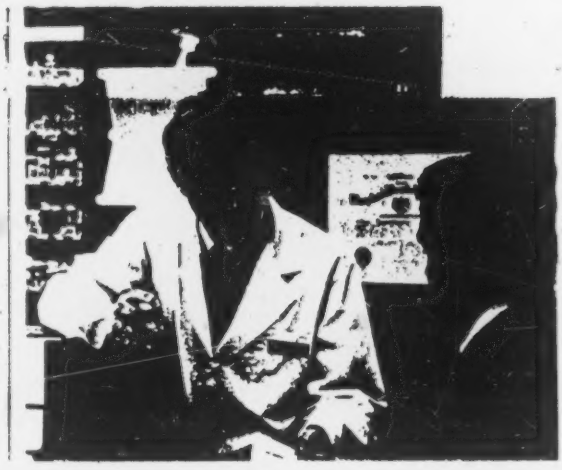
USE MEDICINES SAFELY

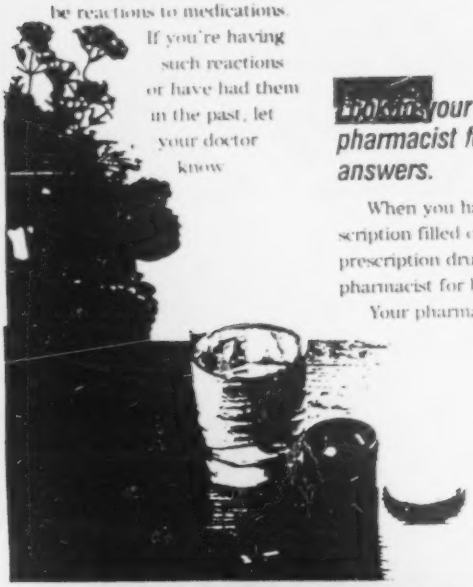
Medicines do many helpful things. They can ease pain and discomfort and improve the way you feel. And they can help speed recovery when you're ill. But medicines can work only when used as directed and coordinated with what you eat and drink and the other drugs you're taking. So, make sure you, your doctor and pharmacist know as much as possible about your medicines.

Your doctor needs your help.

Before your doctor prescribes something new, let him know what medicines you already take. Include those you buy without a prescription, such as laxatives or aspirin, and medicines another doctor has prescribed. When you get a new prescription, ask what it is. What it's supposed to do. And what side effects it could have.



Rashes, indigestion, dizziness and drowsiness can be reactions to medications. If you're having such reactions or have had them in the past, let your doctor know.



Look to your pharmacist for answers.

When you have a prescription filled or buy nonprescription drugs, ask your pharmacist for help.

Your pharmacist may keep a record of all the medicines you're taking. If not, maintain your own list and let your pharmacist see it before you make a purchase.

Ask if there are any special instructions about foods, beverages or other medications while you're taking certain medicines. And if there are any special rules for storage.

If you find label instructions hard to read, ask for larger type. You can also ask your pharmacist to give you easy-to-open containers.

For a Better Life

A Service of the National Association of Retail Druggists
in Cooperation with
the Office of Disease Prevention and Health Promotion
Public Health Service, U.S. Department of Health and Human Services.

Item 4

JOHN MELCHER, MONTANA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

August 21, 1987

John F. Schlegel, Pharm.D.
President
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Dear Dr. Schlegel:

I would like to thank you once again for appearing before the Senate Special Committee on Aging on July 20 and testifying about the burdens of prescription drug costs on the elderly. Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are important. I would like to take the opportunity to request your cooperation in answering the following questions:

1. AARP suggests one possible way to keep administrative costs down in an expanded Medicare prescription drug benefit would be to enroll "participating pharmacies". This approach would be similar to Medicare's "participating physician" program. What does APhA think of this program?

2. During the hearing, we received information about the elderly who don't properly use their presciptions because of costs, or because they forget due to the fact that they are taking too many medications, or because their physician has unintentionally overprescribed medications. How can the Committee help to formulate a prescription drug plan that will encourage greater compliance among patients? Further, what can we do to encourage cooperation between the pharmacist and the physician as a means of providing better patient care?

3. Has your association taken a position on the Medicare prescription drug benefit included in H.R. 2941, the catastrophic health care legislation? What would be APhA's highest priority if it could modify the House version of the drug benefit?

4. Is APhA uneasy about the potential administrative headaches its members would probably have to face with new Medicare prescription drug program, to say nothing of dealing with a bureaucracy that would likely set prices administratively? Has your association given full consideration to the effects of such a program?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by September 4. Therefore, we request that you relay your answers to the above questions prior to that date. Once the hearing print is published, we will be sure to send you a copy.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

Chairman

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The National Professional Society of Pharmacists

John F. Schlegel, PharmD
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D. Stephen Crawford
Chairman of the Board

September 3, 1987

The Honorable John Melcher
Chairman, Special Committee on Aging
United States Senate
Washington, DC 20510-6400

Dear Mr. Chairman:

Thank you for your letter of August 21 and the opportunity to respond to further questions on the issue of pharmaceutical services and prescription drugs for the nations's elderly. We very much appreciated the opportunity to present testimony before your committee in July.

The questions raised in your August 21 letter are certainly relevant to the issue at hand. Without restating each question completely, let me address each in turn.

1. The concept of participating pharmacies is consistent with our view of how any insurance program, catastrophic or otherwise, should be structured. Pharmacists should always have the option of choosing to participate in a given program based on a thorough evaluation of that program. Whether or not this approach has a significant potential for cost saving is not entirely clear because administrative costs generated by prescription drug benefits programs are generally driven primarily by claims volume, not by the number of pharmacists participating in the program.

If large numbers of pharmacists choose not to participate, that of course would be another matter. If that were to occur, access to the program by the nation's elderly would certainly be adversely affected. It is therefore crucial that any proposed insurance program provide for adequate reimbursement to the pharmacist for professional services to ensure their willingness to participate.

2. As was brought out several times in the hearing on July 20, the issues of medication use in the elderly, patient compliance and "polypharmacy" are of concern to many, and certainly to pharmacists. A very effective way to deal with many of these issues is to encourage an ongoing and consistent professional relationship between the patient and his/her pharmacist. Patients should be encouraged to patronize the same pharmacy consistently. This allows the pharmacist to maintain a more complete record of the patient's medication regimen, and improves the chances for identifying compliance and drug interaction problems. APhA has also argued for limiting the supply of medication per encounter to 30 days, which allows for more frequent re-entry of the patient into the "system" for evaluation and screening for such problems.

With regard to the issue of pharmacist/physician cooperation, we feel that the professional dialogue between physicians and pharmacists is certainly crucial, and we have always encouraged both professions to work together cooperatively on behalf of the patient. However, this must be primarily a responsbility of the professionals themselves based upon the level of trust and respect that already exists. Attempting to legislate such interaction would be neither functional nor prudent.

3. APhA has indeed worked closely with members of the House of Representatives and their staffs on H.R.2941. We have been clearly in support of inclusion of pharmaceutical services and prescription drug products in any program of catastrophic care coverage. In our July 20 testimony we stressed the importance of not artificially unbundling pharmaceutical and medical services, since they are so necessarily intertwined in benefitting the patient.

We continue to be concerned about certain aspects of the proposed legislation, however, and are continuing to work with those involved in both the House and Senate to promote provisions which insure both a high quality program for beneficiaries and a program which will engender pharmacist participation and support.

Our major concern with the House bill is the unacceptably infrequent (bi-annual) revision of the data used to calculate reimbursement to the pharmacist for acquisition costs of pharmaceuticals. As is well known, the prices of pharmaceuticals have risen both frequently and substantially in recent years, and this expense impacts just as much on the pharmacist as it does on the patient. The pharmacist must have the pharmaceutical products in his inventory to be able to provide that portion of his services to the patient. Adjusting the reimbursement calculations for acquisition of pharmaceuticals only once or twice yearly will require the pharmacist to absorb what can often be substantial increases in pharmaceutical prices. An equitable resolution of this issue is essential to the willingness and ability of pharmacists to participate in the program.

4. APhA has indeed given full consideration to the effects of the program currently under consideration. APhA has advocated the inclusion of pharmaceutical services and prescription drug products in the Medicare program for many years -- long before the current discussion related to catastrophic illness. Certainly any program of this type and magnitude presents administrative challenges; however, careful design and planning, utilizing currently available and accepted systems and procedures, can overcome any anticipated problems. For example, universal third party claim form usage, promotion and utilization of electronic claims processing, and other measures can minimize administrative problems and costs. Most pharmacists have participated in providing pharmaceutical services to beneficiaries of other third party programs for quite some time. The difficulties encountered, particularly in recent years, often relate much more to adequacy of compensation for services than to major problems with the bureaucratic and administrative system. Simply stated, maximum participation in any such program by pharmacists will be assured if the pharmacist's full range of services are recognized, utilized and fairly compensated.

Again, we thank you for this opportunity to present our views on this issue of importance for both our nation's elderly and our pharmacist members. Please do not hesitate to call upon us further if we can be of assistance to you and your staff as you deliberate on this issue in the weeks ahead.

Sincerely yours,

John Schlegel

John F. Schlegel, PharmD
President

JFS/mpw

Item 5

JOHN MELCHER, MONTANA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

August 21, 1987

Mr. Robert F. Allnutt
Executive Vice President
Pharmaceutical Manufacturers Association
1100 15th Street, N.W.
Suite 900
Washington, D.C. 20006

Dear Mr. Allnut:

I would like to thank you once again for appearing before the Senate Special Committee on Aging on July 20 and testifying about the burdens of prescription drug costs on the elderly. Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are important. Therefore, I would like to take the opportunity to request your cooperation in answering the following questions:

1. From January, 1980 through 1986, the cost of prescription drugs has increased about 80 percent, which is two and one-half times faster than the rise in consumer prices in general. According to data put into the record for a hearing on pharmaceutical drug prices held by the Consumer Interests Subcommittee of the House Select Committee on Aging in October of 1986, the pharmaceutical manufacturers are making up to three times the average profits for all manufacturing corporations. (The Committee's data was taken from a FTC report and covered the years from 1967 to 1984). This is a sizable increase, and it is difficult to believe that it can be completely attributed to greater research and development expenditures and the Food and Drug Administration (FDA) drug approval process. What portion of these increases can be directly attributed to these last two factors? What other factors are involved in these increases that we hear so much about when we visit senior centers?

2. Mr. Allnutt, you stated in your testimony that any program providing coverage for the costs of prescription drugs should be targeted to those most in need. What are PMA's recommendations as to how this would best be accomplished? Do you think states are better able to administer this type of program, through an expansion of the Medicaid program, for example, than the federal government?

3. You advocated in your statement that a comprehensive study be undertaken before a drug-benefit program is enacted. An earlier witness cited studies, including the National Medical Care Utilization and Expenditure Survey, which appear to contain abundant data on the prescription drug utilization and expenditure patterns of the elderly. Given this, why do we need another study?

4. You noted in your statement that none of the estimates of providing a new program of drug coverage under Medicare takes into account the substantial cost of medicines for AIDS victims that would be paid under H.R. 2941. Most AIDS victims have to wait 24 months after qualifying for social security disability before qualifying for Medicare and most victims die before they can qualify for Medicare. Can you elaborate on why you believe the House legislation would result in substantial costs because of AIDS?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by September 4. Therefore, we request that you relay your answers to the above questions prior to that date. Once the hearing print is published, we will be sure to send you a copy.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

Chairman

Robert P. Allnutt
EXECUTIVE VICE PRESIDENT

Pharmaceutical Manufacturers Association

September 3, 1987

The Honorable John Melcher
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510-6400

Dear Mr. Chairman:

Thank you for your letter of August 21, 1987, asking for my answers to additional questions that you and Senator Grassley propounded in connection with the Committee hearing of July 20 on prescription drug use by the elderly.

I have set forth below your questions and my answers.

Question 1. From January, 1980 through 1986, the cost of prescription drugs has increased about 80 percent, which is two and one-half times faster than the rise in consumer prices in general. According to data put into the record for a hearing on pharmaceutical drug prices held by the Consumer Interests Subcommittee of the House Select Committee on Aging in October of 1986, the pharmaceutical manufacturers are making up to three times the average profits for all manufacturing corporations. (The Committee's data was taken from a FTC report and covered the years from 1967 to 1984). This is a sizable increase, and it is difficult to believe that it can be completely attributed to greater research and development expenditures and the Food and Drug Administration (FDA) drug approval process. What portion of these increases can be directly attributed to these last two factors? What other factors are involved in these increases that we hear so much about when we visit senior centers?

Answer 1. The pharmaceutical industry's commitment to research and development is a major factor in drug price increases in recent years; we have never stated that price increases are completely attributable to increases in R&D expenditures.

In recent years, the costs of providing health care, and the prices charged, have risen substantially. The same is true for prescription drugs. But modern prescription drugs are a very good value. Prescription drug prices have remained well below the overall Consumer Price Index ever since that index was set at 100 in 1967. And drug prices today are less than two-thirds the overall price index for medical care. Prescription drugs and related products sold in retail pharmacies in 1985 were half of the 1960 level as a percentage of health care costs. In 1967, a typical worker had to work one hour and twenty minutes to pay for an average prescription; by 1985, it took only 63 minutes to pay for that prescription.

Research and development are the hallmarks of the PMA member companies. Their investment in R&D continues to double every five years. Moreover, the industry is investing an increasingly higher percentage of sales -- currently 15% -- to finance its growing investment in R&D. Measuring increases in R&D expenditures the same way we measure price increases, the "index" for R&D conducted by PMA companies now stands at over 1,000, three and one-half times the prescription drug CPI.

The period of time during which this enormous investment in R&D can be recovered through sales revenues is being dramatically compressed due to a number of converging forces. Foremost is the unprecedented surge in competition from generic products as soon as the patent on the pioneer drug expires. Other major forces include the intense competition within the research-based pharmaceutical industry to develop and market new patented drugs; increasing delays in the approval of new drugs; and increasing foreign competition from developed countries that have targeted this industry and from newly industrialized countries that blatantly condone patent piracy.

Nevertheless, our companies so far remain competitive in world markets. The U.S. pharmaceutical industry, despite its relatively small size, ranks fourth among the ten leading high-technology industries in contributing a positive trade balance. In 1986, for the first time, those ten industries had a net negative balance of trade, totaling $2.6 billion, but pharmaceuticals contributed a positive balance of $764 million. But our industry's leadership position in world markets is not assured. From 1976 through 1980, the U.S. pharmaceutical industry contributed 70 new drugs to world markets, more than one-fourth of the total and twice the number originating from Japan. In sharp distinction, during the last five years, Japan introduced 60 new drugs into world markets as compared with 58 originating from the United States.

Congress can -- and should -- take several important steps to help restrain the forces tending to drive up prices of modern medicines. These include appropriating the funds necessary to streamline the new-drug approval process at the Food and Drug Administration; continuing to encourage other countries to strengthen the protection of patents and trademarks; protecting U.S. process patents from foreign pirates; reforming our chaotic product-liability system; and strengthening the tax incentives for research and development.

As the FTC study cited in your question indicates, the pharmaceutical manufacturing industry is profitable. Both the research-based industry and publicly-held generic-only manufacturers offer good returns to investors. I believe that most economists would agree that risk-taking companies like the research-based industry should strive to produce higher-than-average profit margins.

The research-based pharmaceutical industry stands on the threshold of a golden age of development. New and exciting knowledge about molecular biology, and new methods of research and development -- including computer modeling of molecules and cells and advances in biotechnology -- will enable PMA companies to develop new treatments and cures for such deadly diseases as cancer, heart disease, Alzheimer's disease, leukemia and AIDS. These dreams will become a reality only if incentives remain for the research-based pharmaceutical industry to continue its enormous investment in research and development.

Question 2. Mr. Allnutt, you stated in your testimony that any program providing coverage for the costs of prescription drugs should be targeted to those most in need. What are PMA's recommendations as to how this would best be accomplished? Do you think states are better able to administer this type of program, through an expansion of the Medicaid program, for example, than the federal government?

Answer 2. The most effective way to ensure that pharmaceutical assistance is "targeted to those most in need" is to adopt a means-tested program, through extension of Medicaid or through a new, separate program. In such a program only those individuals below a certain income level would qualify for assistance or, alternatively, the benefit would decrease at higher income levels. Given the finite limits on the ability of the elderly to support a program through premiums, and on available government resources, this ensures that program funds for the most part will be focused on assisting individuals in need of help. This approach also corrects a major deficiency associated with a high deductible for all individuals -- namely, that for someone with very low income, a substantial deductible may have the effect of denying access to pharmaceutical assistance.

There can be little doubt that state governments are in a much better position to administer a pharmaceutical assistance program -- whether or not it is a means-tested program. The best evidence of state governments' capacity in this area is provided by the fact that 49 states now administer a Medicaid drug benefit and 9 states have already recognized the need for a pharmaceutical assistance to the aged program, and have developed programs that are means-tested and designed to meet the needs of their own citizens.

Whether a state program of this type is established as a separate program (as has been done in these 9 states) or as an adjunct to the Medicaid program, it is apparent that administration of such programs is better left to state governments.

State administration takes advantage of the unique benefits of the Federal system. For example, states are better able to develop policies that ensure proper utilization of the program. Recipient restriction programs, whereby the small number of individuals who abuse the Medicaid drug program can be "locked-in" to specified pharmacies or physicians, can be implemented at the state level, and have been shown to be extremely effective in reducing unnecessary (and costly) utilization. It is difficult to see how such a program could be operated out of Washington, D.C. Similarly, there are other "fraud and abuse" initiatives that are most likely to be successful if left to the states.

Additionally, some states have successfully implemented drug utilization review (DUR) programs under Medicaid. These DUR programs have been shown not only to be cost-effective in preventing unnecessary hospitalization, but also have led to improved drug therapy. Such programs have generally involved practitioners in a non-coercive and cooperative arrangement with administrators -- a relationship which could hardly be implemented at the Federal level.

Recipient restriction programs, other fraud and abuse initiatives, and DUR represent only a few obvious examples of why state administration of pharmaceutical assistance programs for the elderly makes sense. Other illustrations, such as prescribed limits on the quantity of drugs dispensed per prescription, could be used to cite the advantages of state policy determinations which are based on factors that may vary significantly from state to state. Finally, a program involving state administration, even if tied to Federal funds, could afford greater flexibility and innovation in terms of providing incentives for states to experiment with various policy options.

Question 3. You advocated in your statement that a comprehensive study be undertaken before a drug-benefit program is enacted. An earlier witness cited studies, including the National Medical Care Utilization and Expenditure Survey, which appear to contain abundant data on the prescription drug utilization and expenditure patterns of the elderly. Given this, why do we need another study?

Answer 3. The wide variation in estimates by the actuaries at the Health Care Financing Administration and experts at the Congressional Budget Office demonstrates the problem of dealing with a paucity of current data. There are several studies that include outdated data on drug utilization and expenditure patterns of the elderly. These studies include the Current Medicare Survey (last conducted in 1977), the 1977 National Medical Care Expenditure Survey, and the 1980 National Medical Care Utilization and Expenditure Survey. Taken together, these studies might have been appropriate bases upon which to plan a prescription drug benefit for the early 1980s. Unfortunately, we are faced with planning a program for 1989 or 1990 with decade-old data. Projecting these data to 1989 requires many assumptions about how utilization patterns may have changed since 1977 or 1980, given significant improvements in drug therapy, major changes in opportunities for insurance coverage of drug expenses and strong improvements in economic status of the elderly. Depending on the assumptions adopted, two independent analyses of the same data base can reach very different conclusions, as have HCFA and CBO.

We believe that the costs of a drug benefit program need to be assessed based on accurate data to ensure that the program is not seriously under-funded. If a new drug benefit is to be targeted at those most in need of assistance, as we feel is necessary, then it is essential that new information be assembled so that we can describe the size and nature of this segment of the elderly population.

Question 4. You noted in your statement that none of the estimates of providing a new program of drug coverage under Medicare takes into account the substantial cost of medicines for AIDS victims that would be paid under H.R. 2941. Most AIDS victims have to wait 24 months after qualifying for social security disability before qualifying for Medicare and most victims die before they can qualify for Medicare. Can you elaborate on why you believe the House legislation would result in substantial costs because of AIDS?

Answer 4. Clearly, the financial plight of most AIDS victims needs to be urgently addressed by Federal, state and local governments, as well as by private organizations. Under the House legislation (H.R. 2470), AIDS victims who wait 24 months to qualify for Medicare as disabled persons also would qualify for the drug benefit. As your question notes, at present, most AIDS victims do not live 24 months and, therefore, would not receive drug benefits. However, one drug -- AZT or Retrovir -- has been approved by the Food and Drug Administration and shown to be effective in arresting the development of AIDS and prolonging the lives of victims. And in view of the massive effort by the research-based pharmaceutical industry to develop drugs to treat AIDS, we believe that an increasingly large number of AIDS victims will live more than 24 months and therefore qualify for the drug benefit under Medicare.

Apart from extended life expectancy for AIDS patients, legislation is pending in the House to accelerate the eligibility of AIDS patients for Medicare (H.R. 276).

Studies have shown that the number of AIDS victims and treatment costs are expected to rise significantly in coming years. At present, according to the Centers for Disease Control, about 36,000 people have AIDS and 1.5 million people carry AIDS antibodies. Within 5 years, up to 30 percent of those with AIDS antibodies are expected to develop the disease. The CDC concludes that, if present trends continue, there will be 10 million to 15 million AIDS carriers in the United States by the year 2010, and 3 million to 5 million diagnosed cases of AIDS.

In early June, the Rand Corporation released a study estimating that the cost of treating AIDS patients will exceed $37 billion from mid-1986 through mid-1991. The figure is based on 400,000 AIDS patients with medical costs of $94,000 each and included only hospital and outpatient care, not the cost of social services or earnings lost due to illness and premature death. An earlier study by the University of California at San Francisco found that the cost of treating AIDS victims would be $66.4 billion in 1991 alone, including $8.5 billion in medical costs, $2.3 billion for social services and research and $55.6 billion in lost earnings. To repeat, we do not take a position on whether the medication costs for AIDS victims should be covered by the Medicare trust fund or some other program. But we wish to point out that neither the CBO or HCFA estimates take these substantial costs into account.

I hope these responses are useful to the Committee.

Thank you again for allowing us to present testimony in your recent hearing.

Best wishes.

Sincerely yours,

Robert F. Allnutt

cc: Senator Grassley

Item 6

JOHN MELCHER, MONTANA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

August 21, 1987

Mr. John Rother
Director, Legislation, Research and Public Policy
American Association of Retired Persons
1909 K Street N.W.
Washington, D.C. 20049

Dear John:

I would like to thank AARP once again for appearing before the Senate Special Committee on Aging on July 20 and testifying about the burdens of prescription drug costs on the elderly. Due to time constraints, Senator Grassley was unable to ask a number of questions. I would like to take this opportunity to request your cooperation in answering the following questions he has submitted for the hearing record:

1. The Senate Catastrophic Health Care Bill contains a provision which calls for a study of the prescription drug benefit. At several points in AARP's testimony, you refer to things we should know more about, including what private health insurance companies cover, what states are doing in this area, and the potential utilization of a full Medicare prescription drug benefit. Why shouldn't we undertake the kind of study or studies called for in the current Senate legislation, and wait for the results before proceeding with this benefit?

2. You endorse the idea of catastrophic coverage for prescription drugs. It can be argued that the idea of catastrophic coverage implies coverage related to income, but your proposal contains any income-related element. Why shouldn't a catastophic prescription drug benefit be related to ability to pay?

3. You noted in your statement that "if actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200." It is hard for me to think of a program in which costs were lower down the road than were projected. Why should we expect our experience with this program to be any different?

The Aging Committee is keeping the hearing record open and will be placing Senator Grassley's follow-up questions and your answers in our print of the hearing's proceedings. It is my intention to submit these additions to the record by September 4. Therefore, I request that you relay your answers to the above questions prior to that date. Once the hearing print is published, I will be sure to send you a copy.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

Chairman

AARP

September 17, 1987

Senator John Melcher
Chairman
Special Committee on Aging
U. S. Senate
Washington, DC 20510

Dear Senator Melcher:

I am responding to your letter of August 21 in which you asked several questions on behalf of Senator Grassley for the record of the July 20 hearing on the high cost of prescription drugs for the elderly.

1. Q. Why shouldn't we undertake the kind of studies called for in the current Senate legislation and wait for the results before proceeding with this benefit?

A. More studies are, of course, always useful. However, they are often used as a convenient excuse for delay. The prescription drug benefit is a tough issue. Many of the hardest questions relate to cost and utilization the answers for which will only come with experience after a benefit is put into place. While there is no federal experience with a drug benefit analagous to what the amendment would do, we do have experience in several of the states. Hence, the best way to gain the information and experience we want, while at the same time not ignoring a critical need, is to proceed with implementing a benefit incorporating both a high enough deductible and coinsurance, limits on costs, and then prepare to refine the technical components of that benefit over a period of time. Ultimately, we believe that this is a serious problem that needs to be addressed now.

2. Q. Why shouldn't the drug benefit be related to ability to pay?

A. Medicare was founded on the principle of social insurance--a principle which recognizes the importance of the Medicare program to all of society, while at the same time requiring that each beneficiary should pay something toward the cost of his or her benefits. This principle ensures broad support for Medicare and guarantees equal access to essential health care benefits.

Our members legitimately fear the erosion of the social insurance concept that would occur if Medicare were to become means-tested. AARP has argued that the catastrophic package should be financed through a combination of premiums, inclusion of all state and local government employees under Medicare, and an increase in the tobacco tax (for the Medicaid components of the package).

3. Q. Why shouldn't we expect this program to overrun costs further down the road?

A. We have learned a lot about cost control in the health area in recent years. Indeed, it was only a few years ago that Medicare's HI Trust Fund was estimated to be insolvent by 1987. However, by applying cost constraints, many of which the Association has supported, the Trust Fund is now seen as solvent to the year 2002. If we are prudent and apply our knowledge from the beginning in enacting legislation to establish effective cost control mechanisms, our task should be easier.

Some of our earlier problems resulted from the effort to gain initial acceptance for the Medicare program. At that time, we stressed access and virtually ignored cost controls. We should not make the same mistake again.

Sincerely,

John Rother

John Rother
Director
Legislation, Research and Public Policy

Item 7

JOHN MELCHER, MONTANA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

August 21, 1987

Helene Levens Lipton, Ph.D.
Associate Professor
Institute for Health Policy Studies
School of Medicine
1326 Third Avenue
San Francisco, California 94143

Dear Dr. Lipton:

I would like to thank you once again for appearing before the Senate Special Committee on Aging on July 20 and testifying about the burdens of prescription drug costs on the elderly. Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are important. Therefore, I would like to take the opportunity to request your cooperation in answering the following questions:

1. You state that, while there have not been many studies on this issue, there clearly appears to be a relationship between noncompliance and high drug costs. Are there any figures at all that you are aware of that could give us an idea of the extent of the problem of noncompliance as a consequence of drug costs?

2. Dr. Lipton, you mention in your prepared testimony that some physicians overprescribe or innappropriately prescribe medications for the elderly. Are you aware of any studies which document this problem and do you have any recommendations about ways in which we could alter this situation?

3. Dr. Lipton you also describe the problems associated with the multple use of drugs. Elderly who require great numbers of medications -- like anyone else who must follow many different directions everyday of their lives -- can get confused or just plain lazy. Do you have any ideas about how our elderly can better comply with directions their pharmacists and doctors give them when they prescribe drugs for them?

4. We know that older people take more prescription medications than do younger age groups, but can you give us any idea of how common the need for multiple medications among older people is? Do we have any data which tell us how many different medications are taken simultaneously by different percentages of the elderly?

5. It is unclear from your statement that the non-poor experience financial hardship as a consequence of prescroption drug outlays. For instance, you said that five percent of the elderly incurred total drug expenditures of $600 or more, and paid 80 percent of this amount out-of-pocket. For what part of that five percent of the elderly do those outlays constitute a financial hardship?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by September 4. Therefore, we request that you relay your answers to the above questions prior to that date. Once the hearing print is published, we will be sure to send you a copy.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

Chairman

Additional Testimony Pertaining to Prescription Drug Costs and the Elderly

Submitted by: Helene Levens Lipton, Ph.D.

1. You state that, while there have not been many studies on this issue, there clearly appears to be a relationship between noncompliance and high drug costs. Are there any figures at all that you are aware of that could give us an idea of the extent of the problem of noncompliance as a consquence of drug costs?

We do not have sound data about the extent to which drug costs influence elderly patients' compliance with drug regimen. There are very few rigorous studies examining this issue. Available studies are limited by small, nonrepresentative samples of elderly patients, vague definitions of compliance, and failure to measure drug costs and compliance independently of patients' self-report. A 1986 national telephone survey conducted by AARP indicated that 17 percent of the respondents did not purchase prescription drugs and the second most cited reason was high drug costs. These figures provide some general indication of the extent of the problem. However, these figures may underestimate the magnitude of noncompliance as a consequence of drug costs because they do not measure the extent to which high drug costs limit the amount of medications the elderly take each day, the regularity with which they take chronic medications, and the frequency with which they fill needed prescriptions. We need to know more about this critical issue.

2. Dr. Lipton, you mention in your prepared testimony that some physicians overprescribe or inappropriately prescribe medications for the elderly. Are you aware of any studies which document this problem and do you have any recommendations about ways in which we could alter this situation?

Inappropriate Physician Prescribing for the Elderly: The Extent and Nature of the Problem

Effective prescription drug therapy depends on rational prescribing by physicians. Too often, this critical element is absent in the care of the

elderly. Although we lack precise data regarding its magnitude, available studies suggest that inappropriate prescribing for the elderly is widespread. Many physicians do not recognize that the elderly are especially susceptible to drug-related problems because of age-related changes in the body's functions regarding drug distribution, metabolism, and excretion (Lamy 1980). Consequently, commonly used drugs such as digoxin and cimetidine are frequently prescribed in dosages excessive for elderly patients (Whiting, Wandless & Sumner 1978; Manning et al. 1980; Campion et al. 1985).

There is also the more insidious problem of side effects that go "undetected, untreated, and unexplained" by physicians (McKenney et al. 1973). These side effects often result from ingestion of many kinds of medications concurrently and contribute to more serious adverse drug reactions. For example, one of the most common causes of reversible dementia is the injudicious use of medications (Kane, Ouslander & Abrass 1984; Beck et al. 1982).

Overmedication is often seen as the major drug misuse problem plaguing the elderly, but undermedication may be an equally serious and frequently overlooked phenomenon. One area in which undermedication is apparent and potentially serious is in the treatment of depression. Physicians may fail to treat depression in elderly patients because it can exhibit atypical symptoms (e.g., mental confusion). When it is correctly identified, it may not be treated at all, for physicians may consider depression an inherent part of the aging process. Even when antidepressant drug therapy is initiated, dosages may be too low because physicians either are overly cautious or are unaware of the availability of a wide variety of antidepressant drugs with differing side-effect profiles. Such variety permits physicians to individualize

therapy by monitoring blood levels (Task Force on Use of Laboratory Tests in Psychiatry 1985).

Another instance of undermedication can be observed in the use of chemotherapeutic agents for cancer. Geriatric patients often are omitted from chemotherapeutic treatment for fear that they will develop life-threatening toxicities. When they are placed on chemotherapeutic treatment, clinicians may assume that the dosages of these drugs should be reduced because of the potential for serious adverse drug reactions. In fact, recent evidence suggests that in order to produce any therapeutic effect in older adults, these agents must be given in full dosages (Kelly 1986).

Inappropriate prescribing of medications, especially psychostrpic agents, is particularly acute in nursing homes. About one-half of all nursing home residents take some form of tranquilizer. Residents often receive sedatives on a nightly basis for extended periods of time, and a considerable number of these residents experience adverse reactions (e.g., mental confusion) from chronic use (Marttila et al., 1977). Because they can decrease alertness, affect judgment and balance, and cause dizziness, sedative-hypnotics contribute to an increased risk of falls among elderly nursing home residents (Sobel & McCart 1983). Such falls can lead to hip and vertebral fractures, with accompanying morbidity and mortality (MacDonald & MacDonald 1977; Ray et al. 1987). Other drugs routinely given to nursing home residents--major tranquilizers, tricyclic antidepressants, antihypertensives and diuretics--are also suspected of causing falls because of effects similar to those of sedative-hypnotics (MacDonald 1984; Sobel & McCart 1983).

Strategies for Action

One exciting and innovative approach to improving physicians' prescribing involves the public interest detailer--a physician or pharmacist sponsored by

a medical school or medical society. The public-interest detailer provides physicians with up-to-date and unbiased information about drug therapy. Studies have shown that these health professionals can improve the accuracy and appropriateness of physician prescribing (Avorn and Soumerai 1983; Schaffner et al. 1983), and that the reduction in unnecessary drug expenditures produce savings greater than program costs (Soumerai & Avorn 1986).

Given these promising results, the Medicare program should consider funding large-scale demonstration projects to evaluate the effectiveness of using clinical pharmacists and physicians as drug consultants to physicians. Public-interest detailing could be performed on a regional basis by medical and/or pharmacy schools under contract with HCFA. If public-interest detailing proves effective on a national scale, it could be integrated into the Medicare program.

3. Dr. Lipton, you also describe the problems associated with the multiple use of drugs. Elderly, who require great numbers of medications--like anyone else who must follow many different directions everyday of their lives--can get confused or just plain lazy. Do you have any ideas about how our elderly can better comply with directions their pharmacists and doctors give them when they prescribe drugs for them?

Physicians and pharmacists can reduce the risk of noncompliance in patients who have multiple drug regimens by placing not only the name but also the purpose of each drug on the prescription container. Labeling of this kind reduces chances of errors, especially the errors that can be made when there are prescriptions from more than one physician and/or when prescriptions are filled by many different pharmacists.

Careful labeling requires that the physician be willing to write the purpose of the drug on the prescription and that the pharmacist be willing to

talk to the physicians if the instructions are not clear to the patient. Such labeling should be simple, direct, and in terminology easily understood by elderly patients: for example, "digoxin - heart pill;" "ampicillin - antiboiotic for infection;" and "lasix - water pill."

Another way to help patients taking multiple medications involves simplifying the regimens. Physicians and pharmacists should examine each regimen and make certain that it is the safest, simplest, and most effective therapy available. Every effort should be made to simplify scheduling. For example, instead of prescribing digoxin every other day, a physician might change the scheduling so that a smaller dosage is taken every day. Given the slower renal excretion rate in the older adult, this change would result in more effective therapy as well as provide a means to improve compliance. A physician might also prescribe a medication with a long half-life on a once-daily or twice-daily basis, as opposed to three or four times daily. In addition, efforts should be made to titrate medications against treatment response in order to determine the smallest amount of medication required. Finally, whenever feasible, unnecessary medications should be eliminated (Sherman, Warach & Libow 1979). For example, the prescription of potassium supplements for a patient taking diuretics is not always necessary if the patient does not have a clinically significant potassium deficit or is not taking a digitalis preparation.

When it is not feasible or desirable to simplify a complex regimen, pharmacists may use a patient profile system to question patients about drug use and to determine whether drugs are being refilled promptly. The format of patient profiles can range from file cards to the computer-based systems that are now readily available. Prescriptions in such computer systems are filed

by name as well as number. The system requirements vary, but the basic components involve a brief history of the patient to determine health status, diagnoses, current drug regimen (including both prescription and nonprescription drugs), dates of drug refills, drug allergies, health insurance coverage, and names and specialties of physicians. By maintaining patient profiles, the pharmacist can also guard against adverse reactions, drug-drug interactions that may mitigate the effects of prescription drugs, and drug-food interactions that may enhance or inhibit drug effects.

Patient package inserts (PPIs) or similar drug information materials can be provided to elderly patients on multiple medications in order to reinforce health professionals' oral instructions and to serve as home reference guides. Written information works best in combination with oral counseling from physicians and pharamcists. Patients' use of medications should be monitored at periodic intervals since patients' compliance with drug regimen often decreases over time. Drug consultations should be provided by means of a nonthreatening and nonjudgmental line of questioning.

4. We know that older people take more prescription medications than do younger age groups, but can you give us any idea of how common the need for multiple medications among older people is? Do we have any data which tell us how many different medications are taken <u>simultaneously</u> by different percentages of the elderly?

The 11 percent of Americans who are elderly receive almost 30 percent of all prescription drugs used in this country. Among the elderly who are not in hospitals or nursing homes, 85 percent use drugs on a regular basis: 67 percent take at least one drug daily, and 25 percent take three or more drugs daily. The corresponding figures for younger persons are 43 percent and 9 percent (American Association of Retired Persons 1984).

5. It is unclear from your statement that the non-poor experience financial hardship as a consequence of prescription drug outlays. For instance, you said that five percent of the elderly incurred total drug expenditures of $600 or more, and paid 80 percent of this amount out-of-pocket. For what part of that five percent of the elderly do those outlays constitute a financial hardship?

We need much more comprehensive and detailed information about the nature of drug insurance coverage for the elderly. There is information suggesting that many of the private health insurance policies purchased by elderly individuals to supplement Medicare include some coverage for prescription drugs, but we do not know how comprehensive such coverage is (e.g., deductible levels, co-insurance and co-payment provisions, etc.).

Some information regarding the burden of out-of-pocket drug expenditures can be derived from national health surveys. A national household survey sponsored by the National Center for Health Services Research in 1977 found that the percentage of annual expenses for prescribed medicines paid out-of-pocket by the family was about 73 percent for the entire population; this share was only slightly higher for the elderly - 77 percent (Kasper 1982). The share of annual expenses for prescribed medicines paid by private insurance was 13.6 percent for the entire population and 10.3 percent for the elderly. The share of annual prescription drug expenses paid by Medicaid was 7.7 percent for the total population and 9.5 percent for the elderly (Kasper 1982). These figures are fairly consistent with results from a 1980 national survey indicating that approximately 68 percent of total charges incurred by aged Medicare beneficiaries for prescription drugs were paid out-of-pocket; 13.9 percent were paid by private insurance; and 10.8 percent were paid by Medicaid (LaVange & Silverman 1987).

Unfortunately, these data are not analyzed by socioeconomic status of the elderly nor by their drug insurance status. More information is clearly needed about these critical issues. Interestingly, H.R. 2470--a bill that would cover prescription drug expenses for elderly Medicare beneificiaries whose drug charges exceed $500 per year--includes a provision authorizing a study to examine the distribution of drug expenditures incurred by Medicare beneficiaries and the sources of payment for such expenditures. Such a survey would provide valuable information with which to inform public policy.

9

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